Hawley Orthodontics

10212 South 71st Street
Papillion, NE 68133

ORTHODONTICS FOR
CHILDREN, TEENS & ADULTS

402.592.3200 www.hawleyorthodontics.com

Welcome! *Our specialty is creating smiles for life. Please provide an answer for each question listed. If the question doesn't apply to you or you don't have the information, please type N/A in the field.*

Patient Information Appointment:

Patient's Name ____________________ **Nickname** ____________________

Patient's Address ____________________ **City** __________ **State** ______ **Zip** __________

E-mail address ____________________ **Home phone** __________

Date of birth __________ **Age** __________ **Race** __________ **Gender** __________ **Cell phone** __________

School/Employer ____________________ **Grade/position** __________ **Work phone** __________

Interests/sports/hobbies ____________________

Responsible Party

☐ **Mother** ☐ **Father** ☐ **Stepparent** ☐ **Self** ☐ **Other (specify)** ____________________

Name ____________________ **Home phone** __________

Address __________ **City** __________ **State** ______ **Zip** __________ **Cell phone** __________

Employer name ____________________ **Work phone** __________

Social Security number __________ **Date of birth** __________ **E-mail address** __________

Dental insurance:

Company Name ____________________ **Phone Number** __________ **Subscriber ID** __________

Responsible Party

☐ Mother ☐ Father ☐ Stepparent ☐ Self ☐ Other (specify) ____________________

Name ____________________ **Home phone** __________

Address __________ **City** __________ **State** ______ **Zip** __________ **Cell phone** __________

Employer name ____________________ **Work phone** __________

Social Security number __________ **Date of birth** __________ **E-mail address** __________

Dental insurance:

Company Name ____________________ **Phone Number** __________ **Subscriber ID** __________

Other Information

Reason for consultation ____________________

How did you hear about our office ____________________

Present Dentist ____________________ **Date of last cleaning** __________

Name(s) of immediate family members who are/have been seen by Dr. Hawley ____________________

☐ Yes ☐ No Have you ever seen an orthodontist?

☐ Yes ☐ No Any dental restorations still needing to be completed?

Medical History

Does the patient have a history of the following medical conditions? Check **Yes** or **No** on each.

Condition		Condition		Condition	
AIDS/HIV	☐ Yes ☐ No	Drug allergies	☐ Yes ☐ No	Nervous disorders	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Endocrine problems	☐ Yes ☐ No	Organ transplant	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emotional disorders	☐ Yes ☐ No	Painful chewing	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Periodontal problems	☐ Yes ☐ No
Aspirin regimen	☐ Yes ☐ No	Fainting, dizziness	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Finger sucking	☐ Yes ☐ No	Prolonged bleeding	☐ Yes ☐ No
Bone disorders	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart condition	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Cerebral palsy	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Sleep apnea	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Speech problems	☐ Yes ☐ No
Chronic neck pain	☐ Yes ☐ No	Immune problems	☐ Yes ☐ No	Thumb sucking	☐ Yes ☐ No
Clicking of jaw	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No	When stopped?	____________
Cold sores/herpes	☐ Yes ☐ No	Latex allergy	☐ Yes ☐ No	TMJ problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No	Tongue habit	☐ Yes ☐ No
Down Syndrome	☐ Yes ☐ No	Muscular disorders	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Please explain any Yes answers from above ____

____

____

Any diseases, problems or allergies not mentioned above? ____

List current prescription and over-the-counter medications____

____

☐ Yes ☐ No Are antibiotics necessary prior to treatment?

☐ Yes ☐ No Have the tonsils and/or adenoids been removed?

☐ Yes ☐ No Are you a mouth breather?

☐ Yes ☐ No Have there ever been any injuries to the face, mouth or teeth?______________________________

☐ Yes ☐ No Have you ever lost or chipped any teeth?____

☐ Yes ☐ No Do your gums bleed when you brush?

☐ Yes ☐ No Do you have tension headaches?

☐ Yes ☐ No Do you have any pain or soreness around your face, neck or back?

☐ Yes ☐ No Are your teeth or jaws ever uncomfortable when you awaken in the morning?

☐ Yes ☐ No Are you aware of clenching your teeth during the day?

☐ Yes ☐ No Have you ever been told that you grind your teeth?

☐ Yes ☐ No Is any part of your mouth sensitive to temperature or pressure? ____________________________

☐ Yes Are you aware that some appointments will be during school/work hours?

Signed Consent

I hereby authorize the office of Hawley Orthodontics to perform an orthodontic evaluation and consent to the taking of x-rays, photographs and other records (if necessary) to determine appropriate orthodontic treatment on the above-named patient.

I also authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

Typed name/signature________________________________ Relationship to patient________________ Date ______________