HANCOCK
ORTHODONTICS

We would like to welcome you to our office. Please complete both sides of this form. All information is confidential. Thank you.

Patient Information

Patient Name: _____ Date:_____
Last Name First Name Middle Initial

Address: _____
Street City State Zip

Age: _____Birth Date: _____ Home Phone: _____ Cell Phone:_____

Work Phone: _____ Email: _____

If Patient is a minor, give parent or guardian's names: _____

Please circle approved methods of appointment reminders: Cell Phone Home Phone Email

Who may we thank for referring you to our office? _____

IF UNDER 18

School: _____ Siblings: _____

Hobbies: _____ Grade: _____

Has any family member had braces before? If so, who? _____

Can we use your photo on social media or for advertising? ____ No ____Yes

RESPONSIBLE PARTY

First name: _____ Last Name: _____ MI: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Email:_____

Work Phone: _____ Relation to Patient: _____ SS# _____-_____-_____

Employer: _____ Occupation: _____

Employer's address and phone number _____

Spouses Name: _____ Occupation: _____ Relation to patient: _____

DENTAL INSURANCE INFORMATION

Full Name of Insured: _____ Birth Date: _____

Relation to Patient _____ Home phone: _____

Mailing address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Insurance Company: _____ ID#/SS# _____ Group # _____

Insurance Co Address and Phone number: _____

Medicaid Yes ☐ No ☐ Employer if different from responsible party :_____

ADDITIONAL DENTAL INSURANCE INFORMATION

Full Name of Insured: _____ Birth Date: _____

Relation to Patient _____ Home phone: _____

Mailing address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Insurance Company: _____ ID#/SS#_____ Group # _____

Insurance Co Address and Phone number: _____

Employer if different from above: _____

IN CASE OF EMERGENCY

Notify in case of emergency: _____Phone:_____

Relationship to Patient: _____

Notice of Privacy Practices and Acknowledgement of Receipt

Consent to the use and disclosure of Health Information for treatment or payment purposes

Our office takes great care to protect your privacy relating to your health records describing your health history, examination results and diagnoses, treatments, and any plans for future care or treatment.

This information serves as a basis for planning your orthodontic care and treatment, a means of communication among the various health professionals who contribute to your care, and a source of information for billing purposes necessary for this office and/or a third-party payer. Any information you share with this office will be used for these purposes only.

I have read the above Notice of Privacy Practices and received a copy (if requested).

_____

Patients Name (Printed)

_____ _____

Parent or Guardian's Name (Printed) **Relationship to Patient**

_____ _____

Signature **Date**

DENTAL/MEDICAL HISTORY

Dentist's Name: _____ Phone: _____ Date of last cleaning?_____

Physician's Name _____ Phone: _____ Date of last visit? _____

Has an orthodontist been previously consulted? _____ If so, when? _____ were x-rays taken? _____

Do you have any specific concerns? _____

If patient is a minor: Height of parents Mother _____ Father _____

Is the patient currently under a physician's care? ____ No ____Yes

If yes, for what reason? _____

Do you have any loose teeth? ____ No ____Yes

Are you in dental pain? ____ No ____Yes

Have you ever had periodontal treatment (deep gum cleaning)? ____ No ____Yes

Do your gums bleed when you brush or floss? ____ No ____Yes

Does food frequently get caught between your teeth? ____ No ____Yes

Have the tonsils and adenoids been removed? ____No ____Yes

Have you had any serious illnesses or operations? ____ No ____Yes

Have you ever been involved in a serious accident? ____ No ____Yes

Have you had your first menstruation cycle? ____ No ____Yes

Have you ever had a bad reaction to a medical or dental procedure? ____ No ____Yes

Have you ever lost or chipped any permanent teeth? ____ No ____Yes

Do you have any problems relating to your jaw joint? ____ No ____Yes

Has the patient ever sucked a thumb or finger? Until what age? ____ ____ No ____Yes

Is the patient currently taking and drugs/medications? ____ No ____Yes

If yes please list: _____

Does the patient have any allergies (latex, metal, food, drugs, etc) ? ____ No ____Yes

If yes please list: _____

Has there ever been an adverse reaction to latex or nickel? ____ No ____Yes

Does the patient need antibiotics before seeing the dentist? ____ No ____Yes

Has the patient ever had severe trauma to the face or teeth? ____ No ____Yes

Has the patient ever had an issue with severe cavities? ____ No ____Yes

Have you ever received orthodontic treatment? With whom and when? _____

Please circle any of the following conditions that the patient has had or now has:

Congenital Heart Lesions	Anemia	Epilepsy/Seizures	Jaw/Facial Injuries
Heart Murmur	HIV/AIDS	Fainting Spells	Dental/Tooth Injuries
Rheumatic/Scarlet Fever	Hepatitis	Asthma	Frequent Headaches
Tuberculosis	Kidney Problems	Mouth Breathing	Clenching/grinding of teeth
Persistent Cough	Liver Problems	Speech Problems	Ringing in the ears
Abnormal Bleeding	Stomach ulcers	Canker Sores	Sinus Trouble
High/Low Blood Pressure	Mental Disorders	Jaw Locking	Smoke/Chew tobacco
Diabetes	Arthritis	Sore Facial Muscles	Pregnant now?
Sore or Lumps in Mouth	Chronic Dry Mouth	Sensitive Teeth	Sore jaw in morning
Pacemaker	Thyroid Disorders	Back Problems	Sinus Problems
Nervousness/Anxiety	Eating Disorders	Bone Disorders	Blood Disorder
Cancer or Tumor	Stroke	Transplant Patient	Artificial Joints

Do you have any medical or dental problems not listed above? _____Yes _____No

Please explain_____

_____

_____

AFFIRMATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in the patient's medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay the orthodontist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby give Dr. Hancock and Team permission to confirm appointments using the phone number(s) and email I have provided, to include leaving messages.

_____ _____

Signature Patient/Parent/Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the Patient/Parent Guardian.

Signed: _____ Date: _____