HANOVER ORTHODONTICS

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Patient Information

Date _____

GENERAL INFORMATION:

Patient's Name (Last) _____ (First) _____ (Middle) ____

Street Address _____ Town _____ Zip Code _____

Nickname _____ Age _____ Birthday _____ Home Phone _____

School Attending _____ Grade _____ Referred by _____

Relatives Treated Here _____

Hobbies _____ Siblings _____

PARENT'S INFORMATION:

Father's Name _____ Birthdate _____ SS# _____

Employer _____ Employer's Address _____

Mother's Name _____ Birthdate _____ SS# _____

Employer _____ Employer's Address _____

Father's Work# _____ Mother's Work # _____

e-mail _____

Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

MEDICAL INFORMATION:

Child's Dentist _____ Address _____

Child's Pediatrician _____ Phone _____

Is your child being treated for any condition currently? If yes explain. _____

Is your child taking any medications or drugs? If yes, explain. _____

Has your child ever been hospitalized or had surgery? If yes, explain. _____

Y	N		Y	N		Y	N	
__	__	AIDS	__	__	Convulsions/Seizures	__	__	Hepatitis or Liver Disease
__	__	Asthma	__	__	Diabetes	__	__	Hyperactivity
__	__	Allergies	__	__	Epilepsy	__	__	Oral Ulcers
__	__	Blood transfusions	__	__	Eye Problem	__	__	Orthopedic Problems
__	__	Birth Defects	__	__	Excessive Bleeding Problem	__	__	Premature Birth
__	__	Bone or Joint Problems	__	__	Excessive Gagging	__	__	Rheumatic Fever
__	__	Child Abuse	__	__	Fainting or Dizziness	__	__	Tuberculosis
__	__	Chronic Adenoid/Tonsil Infection	__	__	Growth/Development Problems	__	__	other
__	__	Chronic Headache	__	__	Hearing/Speech Problems			
__	__	Cleft Lip/Palate	__	__	Heart Murmur			
__	__	Congenital Heart Disease	__	__	Hemophilia			

Please describe any current medical treatment including drugs, surgery, recent injuries or any other information we should be aware of that has not been covered.

_____

_____

_____

_____

_____

Signature _____

Member American Association of Orthodontists