Hawley Orthodontics

107 Highland Street
Papillion, NE 68046

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.

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 _____