EPIC ORTHODONTICS
BRADLEY S. HALL, DDS, MS

CONFIDENTIAL Date_____

PATIENT INFORMATION

Name_____Prefer to be called_____Sex_____
Birthdate_____Age in years_____School (If applicable)_____Grade_____
Parents or legal guardian (If applicable)_____
Patient's Address_____City _____Zip_____
Contact phone number (_____)_____Cell Phone_____E-mail_____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____SS#_____Relationship_____ Birthdate:_____
Home Address_____City _____Zip_____
Home Phone (_____)_____Cell Phone_____E-mail_____
Employer _____
Business Address_____Business Phone_____

RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account)

Name _____SS#_____Relationship_____ Birthdate:_____
Home Address_____City _____Zip_____
Home Phone (_____)_____Cell Phone_____E-mail_____
Employer _____
Business Address_____Business Phone_____

Is there another person who may bring patient to appointment? If so, please specify_____
Do you grant us permission to discuss treatment progress with them?_____
Emergency contact_____ Phone number_____
Family physician_____ Family dentist_____
Whom may we thank for referring you to this office?_____
Is the patient covered by orthodontic insurance?_____If yes, please name 1)_____
2)_____

DENTAL QUESTIONNAIRE

What is the main concern for this examination?_____
Was anyone else in the patient's family treated in our office?_____
Does the father have an orthodontic problem?_____Treated_____Mother_____Treated_____
Face and mouth most resembles: Father_____ Mother_____Neither_____Both_____
How many brothers?_____Ages_____Sisters_____Ages_____Is the patient adopted?_____
Height of patient_____Father_____Mother_____Growth of patient last year_____
Describe patient's temperament_____Hobbies or Sports_____
Do you expect a transfer in the future?_____Musical instrument played_____
Have there been any injuries to the face mouth or teeth? _____
Has the patient ever sucked a thumb or fingers?_____Is the habit still present?_____Quit at age_____
Any other habits?_____Does the patient have any speech problems?_____
Is the patient a mouth breather? While awake?_____While asleep?_____
Has the patient been examined or treated by an orthodontist?_____ Please specify_____
When was the patient's last routine dental exam and cleaning?_____
Is there any dental work that needs to be completed?_____Is the patient currently experiencing any dental pain?_____
Does the patient have a history of having multiple cavities?_____Popping or clicking of the jaw joint?_____

Have you ever had or have you now? (Please check to the right of each item)

(Check each item)	YES	NO		YES	NO		YES	NO
Epilepsy or Seizures			Hemophilia			Ulcers		
Fainting or Dizziness			Bruise or Bleed easily			Kidney problems		
Nervousness			Heart problems or Angina			Diabetes		
Stroke			Hypertension			Thyroid problems		
Glaucoma			Rheumatic fever			AIDS or HIV +		
Cold sores/Fever blisters			Heart murmur			Arthritis		
Persistent cough			Mitral valve prolapse			Painful Joints (incl. Jaw)		
Emphysema			Congenital heart lesions			Prosthetic joints		
Tuberculosis/PPD positive			Prosthetic heart valve			Hives		
Asthma			Pacemaker			Steroid medications		
Hay fever			Blood transfusion (s)			Fear of dental treatment		
Sinus problems			Liver disease			Communication difficulties		
Frequent tonsillitis			Yellow jaundice			Mental Heath Disturbance		
Adenoid conditions			Hepatitis- type:			ADD/ADHD		
Osteoporosis			Gastric reflux			Anorexia/Bulimia		
Skin disorders			Hearing Loss			Depression		
Anemia			Ear Pain			Unexplained weight change		
Sickle Cell disease			Frequent headaches			Cancer or Tumor		
Birth defects			Neuromuscular disorders			Radiation/Chemotherapy		

ALLERGIES: (please specify) Drugs or Medications_____

Metals_____ Latex_____Vinyl_____Acrylic_____

Animals_____Foods_____Other substances_____

History of Hospitalizations:_____

Operations:_____

Medications Presently Taking:_____

Does the patient smoke?_____Use chewless tobacco?_____Have or had a substance abuse problem? (please specify)_____

Is the patient currently being treated by another health care professional? _____For?_____

Does the patient have any other physical symptoms or medical conditions not mentioned?_____

Does the patient have any special needs?_____

Women Only: Is the patient pregnant?_____Does she anticipate becoming pregnant within the next two years?_____

FAMILY MEDICAL HISTORY: Do the patients parents or siblings have any of the following? (please specify):

Bleeding Disorders_____Diabetes_____Arthritis_____Severe Allergies_____

Heart disease_____Seizures_____Unusual dental problems_____

Jaw size imbalance_____Other hereditary medical conditions_____

_____ _____

Patient or Guardian's Signature Date Staff Member/Doctor Signature Date

_____ _____

Patient or Guardian's Signature Date Staff Member//Doctor Signature Date