HARDY ORTHODONTICS

A tradition of creating healthy, beautiful, and confident smiles.

Member American Association of Orthodontists

Today's Date _____ ☐ M ☐ F
Patient's Name _____ Nickname _____
Date of Birth _____ Age _____
Home Phone (____)_____ Cell Phone (____)_____
Street Address _____ Mailing Address _____
_____ (if different) _____
Email Address _____
Occupation _____
Employer _____ Business Address _____
Dentist's Name _____ Favorite Music Genre / Band _____
Physician's Name _____ _____
Who referred you to our office? _____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SPOUSE
Name _____ Employer _____
Date of Birth _____ Business Address _____
Occupation _____ _____

INSURANCE INFORMATION

Primary Dental Insurance Company
Policy Holder Name _____
Relationship to patient:
☐ Self ☐ Spouse ☐ Parent
Subscriber's DOB _____
Subscribers SSN _____
Employer _____
Insurance Company _____
Group # _____
ID # _____
Insurance Company #: _____
Claims Mailing Address _____
_____

Secondary Dental Insurance Company
Subscriber _____
Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Parent
Subscriber's DOB _____
Subscribers SSN _____
Employer _____
Insurance Company _____
Group # _____
ID # _____
Insurance Company #: _____
Claims Mailing Address _____
_____

I hereby authorize Hardy Orthodontics to submit claims to my insurance company(ies) and that I am responsible for all balances not covered by insurance for any reason.

Signed Date

Is this patient covered by Mainecare, Medicaid, or any other Maine Assistance program? _____ ☐ Yes ☐ No
If yes, please list the ID# _____
Do you have pending Mainecare, Medicaid, or other Maine Assistance program? _____ ☐ Yes ☐ No
Have you had Mainecare, Medicaid, or other Main Assistance program in the past 12 months? ___ ☐ Yes ☐ No

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MEDICAL / DENTAL HISTORY

Your answers are confidential and for office records only.

1. What are the main orthodontic concerns?

☐ Crowding	☐ Spaces	☐ Missing teeth	☐ Gummy smile
☐ Over-bite	☐ Under-bite	☐ Protrusion	☐ Narrow jaw
☐ Prominent jaw	☐ Receded jaw	☐ Clicking jaw	☐ Irregularly shaped teeth
☐ Gum disease	☐ Jaw pain	☐ Neck pain	☐ Headaches / facial pain
☐ Irregular facial proportions		☐ Other _____	

2. Other family members with similar orthodontic conditions?

☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Other _____

3. Has the patient ever had any of the following conditions?

☐ Birth defect	☐ Bone fracture	☐ Trauma (teeth, face, jaw)	☐ Heart defect/murmur
☐ Asthma	☐ Diabetes	☐ Enlarged tonsils / adenoids	☐ Sleep disturbance
☐ GERD	☐ Cancer	☐ Radiation / Chemotherapy	☐ Thyroid disorder
☐ High or low blood pressure		☐ Frequent ear infections	☐ Seasonal allergies
☐ Kidney disease	☐ Headache / Migraine	☐ Autoimmune disorder	☐ Bleeding disorder
☐ Arteriosclerosis	☐ HIV / AIDS	☐ Hepatitis	☐ Arthritis
☐ Vision, hearing, or speech problem		☐ Mental health problem (anxiety / depression)	
☐ Eating disorder	☐ Skin disorder	☐ Mononucleosis, tuberculosis, pneumonia	

4. Family medical history: *Have your parents or siblings every had any of the following …*

☐ Allergies	☐ Diabetes	☐ Bleeding disorders	☐ Arthritis
☐ Jaw size imbalance		☐ Unusual dental problems	

5. Current medications: _____

6. Allergies: _____

7. Questions:

☐ Y ☐ N	Do you snore?	☐ Y ☐ N	Thumb sucking?
☐ Y ☐ N	Do you have difficulty chewing?	☐ Y ☐ N	Finger sucking?
☐ Y ☐ N	Do you have speech problems?	☐ Y ☐ N	Lip biting or sucking?
☐ Y ☐ N	Do you have sensitive teeth?	☐ Y ☐ N	Teeth grinding?
☐ Y ☐ N	Do you have frequent sore throats?	☐ Y ☐ N	Tongue thrusting?

☐ Y ☐ N Do you take any antibiotic pre-medication before dental procedures?

☐ Y ☐ N Do you smoke or chew tobacco?

☐ Y ☐ N Have you ever had a substance abuse problem?

☐ Y ☐ N Any unusual dental experiences? If yes, please explain _____.

☐ Y ☐ N Any previous orthodontic consultations or treatments?

☐ Y ☐ N Any medical / dental / surgical problems not covered above?
If yes, please explain _____.