Where Healthy, Beautiful Smiles are Created

HILLCREST ORTHODONTICS, PC

Dr. Rosalyn Salter

PATIENT INFORMATION

LAST NAME	FIRST NAME	NICKNAME	SS NO.	SEX	BIRTHDATE	AGE
MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE	CELL PHONE	
WHO REFERRED YOU TO OUR OFFICE?	SCHOOL/EMPLOYER	EMAIL ADDRESS			GRADE/YEARS AT JOB	
NAME OF PATIENT'S PHYSICIAN	DOES PATIENT VISIT DENTIST REGULARLY?	NAME OF GENERAL DENTIST			DATE OF LAST VISIT	
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE		NAMES & AGES OF OTHER CHILDREN				

RESPONSIBLE PARTY INFORMATION (please complete in full)

NAME: ____________________

ADDRESS: ____________________

CITY ______________ ST ________ ZIP ______________

HOW LONG AT THIS ADDRESS? ____________________

HOME NO.: ______________ WORK NO.: ______________

CELL NO.: ____________________

DATE OF BIRTH __________ SS NO. ______________

EMAIL ADDRESS: ____________________

EMPLOYER: ____________________

OCCUPATION: ____________________

HOW LONG EMPLOYED AT THIS JOB? ______________

SPOUSE: ____________________

ADDRESS: ____________________

CITY ______________ ST ________ ZIP ______________

HOW LONG AT THIS ADDRESS? ____________________

HOME NO. ______________ WORK NO. ______________

CELL NO. ____________________

DATE OF BIRTH __________ SS NO. ______________

EMAIL ADDRESS: ____________________

EMPLOYER: ____________________

OCCUPATION: ____________________

HOW LONG EMPLOYED AT THIS JOB? ______________

HEALTH HISTORY

Does patient have/had?

- Y N Heart Attack/Stroke
- Y N Heart Murmur/ Congenital Defect
- Y N Mitral Valve Prolapse
- Y N Stomach Ulcers/Colitis
- Y N HIV+/AIDS
- Y N Hepatitis
- Y N Diabetes
- Y N Severe/Frequent Headaches
- Y N Temporomandibular Disorder (jaw pain)
- Y N Fever Blisters
- Y N Hearing Impairment
- Y N Drug/Alcohol Abuse
- Y N Tobacco User
- Y N Glaucoma/Eye Problems
- Y N Epilepsy/Seizures
- Y N Fainting Spells
- Y N Artificial Bones/ Joints/Valves
- Y N Asthma
- Y N Arthritis
- Y N Wears Contacts
- Y N Sinus Problems
- Y N Cancer/Radiation/ Chemotherapy
- Y N Hemophilia/Anemia/ Abnormal Bleeding/ Blood Transfusion
- Y N Latex allergy

Does the patient have any of the following habits?

- Y N Thumb/Finger/Lip Sucking
- Y N Clenching/Grinding teeth

Has an orthodontist been consulted previously?

Reason:

LIST ANY SERIOUS ILLNESSES:

LIST ANY ALLERGIES:

LIST DRUGS OR MEDICATIONS BEING TAKEN:

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN THE PATIENT'S MEDICAL STATUS. I UNDERSTAND THAT ONCE MY DIAGNOSIS HAS BEEN ESTABLISHED AND A PLAN OF TREATMENT RECOMMENDED, THE FEES INVOLVED AND METHODS OF PAYMENT WILL BE DISCUSSED WITH ME AND A FINANCIAL AGREEMENT ESTABLISHED. I ALSO AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES THE PATIENT MAY NEED.

______________________________ ______________

Signature of Patient or Parent/Guardian if Patient is a Minor Date

IF YOU HAVE DENTAL INSURANCE, PLEASE GIVE US YOUR CARD SO THAT WE CAN MAKE A COPY OF IT IN ORDER TO VERIFY YOUR ORTHODONTIC COVERAGE. THANK YOU.