

# Hillcrest Orthodontics P.C.

*for adults & children*

**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)

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? _____
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## HEALTH HISTORY

Does patient have/had?  <table style="width: 100%;"> <tr> <td>Y N Heart Attack/Stroke</td> <td>Y N Fever Blisters</td> <td>Y N Asthma</td> </tr> <tr> <td>Y N Heart Murmur/ Congenital Defect</td> <td>Y N Hearing Impairment</td> <td>Y N Arthritis</td> </tr> <tr> <td>Y N Mitral Valve Prolapse</td> <td>Y N Drug/Alcohol Abuse</td> <td>Y N Wears Contacts</td> </tr> <tr> <td>Y N Stomach Ulcers/Colitis</td> <td>Y N Tobacco User</td> <td>Y N Sinus Problems</td> </tr> <tr> <td>Y N HIV+/AIDS</td> <td>Y N Glaucoma/Eye Problems</td> <td>Y N Cancer/Radiation/ Chemotherapy</td> </tr> <tr> <td>Y N Hepatitis</td> <td>Y N Epilepsy/Seizures</td> <td>Y N Hemophilia/Anemia/ Abnormal Bleeding/ Blood Transfusion</td> </tr> <tr> <td>Y N Diabetes</td> <td>Y N Fainting Spells</td> <td>Y N Latex allergy</td> </tr> <tr> <td>Y N Severe/Frequent Headaches</td> <td>Y N Artificial Bones/ Joints/Valves</td> <td></td> </tr> </table>	Y N Heart Attack/Stroke	Y N Fever Blisters	Y N Asthma	Y N Heart Murmur/ Congenital Defect	Y N Hearing Impairment	Y N Arthritis	Y N Mitral Valve Prolapse	Y N Drug/Alcohol Abuse	Y N Wears Contacts	Y N Stomach Ulcers/Colitis	Y N Tobacco User	Y N Sinus Problems	Y N HIV+/AIDS	Y N Glaucoma/Eye Problems	Y N Cancer/Radiation/ Chemotherapy	Y N Hepatitis	Y N Epilepsy/Seizures	Y N Hemophilia/Anemia/ Abnormal Bleeding/ Blood Transfusion	Y N Diabetes	Y N Fainting Spells	Y N Latex allergy	Y N Severe/Frequent Headaches	Y N Artificial Bones/ Joints/Valves		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: _____
Y N Heart Attack/Stroke	Y N Fever Blisters	Y N Asthma																							
Y N Heart Murmur/ Congenital Defect	Y N Hearing Impairment	Y N Arthritis																							
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Y N Diabetes	Y N Fainting Spells	Y N Latex allergy																							
Y N Severe/Frequent Headaches	Y N Artificial Bones/ Joints/Valves																								
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.**