Hausman
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Patient Information Form

Patient Information

Patient's Full Name ______________________ Nickname ____________ Age _____ Date of Birth __________

☐ Male ☐ Female Primary Phone # __________________ Secondary Phone # ____________________

Do you like receiving text appointment reminders? Yes No (Please circle above phone number to receive text)

Address ____ State ________ Zip Code __________

Email Address __________________________(parent's if minor) Dentist ____________ Last Appt ________

Whom may we thank for referring you to our office? ____

School __________________________ Hobbies ____

Other parties who may bring patient to appointments ____________________ Relationship to Patient ___________

Responsible Party *(If Responsible Party is Patient, Skip Next 5 Lines)*

Full Name __________________________ Date of Birth __________ Relationship to Patient ____________

☐ Male ☐Female Primary Phone # __________________ Secondary Phone # ____________________

Do you like receiving text appointment reminders? Yes No (Please circle above phone number to receive text)

Address (check if same as above ☐) ____________________________ State _______ Zip Code __________

Email address ____

Employer ________________________ Occupation ______________________ Years employed _______

How long at current residence ____________ Marital Status ____________________

Spouse ____________________ Spouse's Employer ________________________ Years employed _______

Spouse's relationship to patient ________________________ Spouse's phone number _________________

Insurance Information

Insured Name ________________________ Date of Birth _____________ SSN ___________________

Insurance Company _____________________ ID# __________________ Group # _________________

Insurance Company Phone Number ______________________ Insured Employer ____________________

Insurance Company Address ____

Dual Coverage? ☐ YES ☐ NO

Co-Insured Name ______________________ Date of Birth _____________ SSN ___________________

Insurance Company _____________________ ID# __________________ Group # _________________

Insurance Company Phone Number ______________________ Insured Employer ____________________

Insurance Company Address ____

Patient Name: ______________________

MEDICAL CHECKLIST

Does the patient have or ever had any of the following medical conditions?

- ☐ Allergies or asthma
- ☐ Arthritis
- ☐ Breathing difficulties
- ☐ Bleeding disorders
- ☐ Bone Disorders
- ☐ Cancer or tumor(s)
- ☐ Cleft lip/palate
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Endocrine problems
- ☐ Emotional Problems
- ☐ Epilepsy or convulsions
- ☐ Fainting or dizziness
- ☐ Hearing problems
- ☐ Heart disease or murmur
- ☐ Hepatitis/liver disease
- ☐ HIV or AIDS
- ☐ Kidney Problems
- ☐ Learning Disabilities
- ☐ Rheumatic fever
- ☐Rheumatoid arthritis
- ☐ Sleep apnea/sleep disorders
- ☐ Speech problems
- ☐ TMJ
- ☐ Tuberculosis

Other medical conditions not listed: ______________________

MEDICAL HISTORY

Circle One:

Y N Does the patient have a health problem? Please list ______________________
Y N Is there a history of serious illness, accident or operation? Please list ______________________
Y N Is the patient under a doctor's care for any problems at this time? Please list ______________________
Y N Is the patient currently taking any medication? Please list ______________________
Y N Has the patient ever taken bisphosphonate medication? Please list ______________________
Y N Does the patient have any allergies or drug sensitivities (latex, penicillin, etc.)? Please list ______________________
Y N Does the patient have frequent headaches? How often? ______________________
Y N Does the patient use tobacco products? ______________________

DENTAL HISTORY

Date of last dental exam: ______________________

Circle One:

Y N Has the patient had any injury to the teeth? ______________________
Y N Has the patient had any injury to the face, jaws, or chin? ______________________
Y N Does the patient currently need any dental work to be completed (such as fillings or crowns)? ______________________
Y N Does the patient have any missing, extracted, or extra permanent teeth? ______________________
Y N Does the patient have any pain, clicking, or popping noises in the jaw? ______________________
Y N Does the patient clench or grind their teeth? ______________________
Y N Does the patient suck fingers, thumb, or have a similar habit? ______________________
Y N Has the patient had an orthodontic consultation recently? ______________________
Y N Has the patient had any previous orthodontic treatment? ______________________
Y N Have we treated any other family members? ______________________

Reason for seeking orthodontic treatment:

____
____
____

EMERGENCY INFORMATION

Name of nearest relative not living with you: ______________________ Phone: ______________________
Address: ______________________

SIGNATURE

Patient Signature* (*Parent's signature if minor*) ______________________ Date: ____________

**By signing, I agree that the information is true to the best of my knowledge. I have received the Privacy Policies of* Pierson Orthodontics. *I understand that where appropriate credit bureau reports may be obtained.*