Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!

HAMILTON & MANUELE ORTHODONTICS

(702) 243-3300 HMOrtho.com

401 N. Buffalo Drive, Suite 220 | Las Vegas, NV 89145

Patient Information

NAME ______________________ PREFERRED NAME ______________________ M F

BIRTHDATE ____________ AGE ____________ GRADE ____________ SCHOOL ATTENDS ______________________

HOME PHONE ______________________ CELL PHONE ______________________

ADDRESS ______________________ CITY ____________ STATE ______ ZIP ________

NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO TODAY'S APPOINTMENT ______________________

PATIENT LIVES WITH WHOM/RELATIONSHIP ______________________ I understand where appropriate, credit bureau reports may be obtained ______________________ Signature

WHO HAS LEGAL CUSTODY OF PATIENT? ______________________

NAME OF SIBLINGS & AGES ______________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

Responsible Party

☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

MOTHER'S NAME ______________________ FATHER'S NAME ______________________

☐ PARENT ☐ GUARDIAN ☐ STEPMOTHER ☐ PARENT ☐ GUARDIAN ☐ STEPFATHER

DATE OF BIRTH ____________ SSN ____________ DATE OF BIRTH ____________ SSN ____________

ADDRESS ______________________ ADDRESS ______________________

CITY ____________ STATE ______ ZIP ________ CITY ____________ STATE ______ ZIP ________

HOW LONG AT THIS ADDRESS? ______________________ HOW LONG AT THIS ADDRESS? ______________________

CELL PHONE ______________________ CELL PHONE ______________________

WORK PHONE ______________________ WORK PHONE ______________________

EMPLOYER ____________ YEARS EMPLOYED ________ EMPLOYER ____________ YEARS EMPLOYED ________

OCCUPATION ______________________ OCCUPATION ______________________

EMAIL ______________________ EMAIL ______________________

Primary Insurance Information

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY ______________________ INSURANCE PHONE NUMBER ______________________

EMPLOYER/GROUP NAME ______________________ GROUP NUMBER ______________________

SUBSCRIBER/EMPLOYEE ______________________ SUBSCRIBER ID/SSN ______________________

DATE OF BIRTH ______________________ RELATIONSHIP TO PATIENT ______________________

Secondary Insurance Information

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY ______________________ INSURANCE PHONE NUMBER ______________________

EMPLOYER/GROUP NAME ______________________ GROUP NUMBER ______________________

SUBSCRIBER/EMPLOYEE ______________________ SUBSCRIBER ID/SSN ______________________

DATE OF BIRTH ______________________ RELATIONSHIP TO PATIENT ______________________

Emergency Contact Information (OTHER THAN RESPONSIBLE PARTY)

NAME ______________________ RELATIONSHIP TO PATIENT ______________________

HOME PHONE ______________________ CELL PHONE ______________________

PLEASE READ: We are passionate about our mission to give everyone a world changing smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc. _____

Medical History

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

	Y	N
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING?		
4. DO YOU USE TOBACCO?	☐	☐
5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS?	☐	☐
IF YES, WHAT?		
6. FEMALES ONLY:		
A. ARE YOU PREGNANT, OR THINK YOU MAY BE?	☐	☐
7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS?	☐	☐
IF YES, SPECIFY _____		
8. HAS THE PATIENT REACHED PUBERTY?	☐	☐

9. PLEASE CHECK ALL THAT APPLY:

HAY FEVER/ALLERGIES	☐	LEUKEMIA	☐
COLD SORES	☐	KIDNEY/LIVER DISEASE	☐
MIGRAINES	☐	ANEMIA	☐
DIABETES/GLAUCOMA	☐	CANCER	☐
RHEUMATIC FEVER	☐	JOINT REPLACEMENT/IMPLANT	☐
AIDS OR HIV INFECTION	☐	HEPATITIS/JAUNDICE	☐
CARDIAC PACEMAKER	☐	STOMACH TROUBLES/ULCERS	☐
ASTHMA (INHALER)	☐	SINUS PROBLEMS	☐
FAINTING/SEIZURES	☐	STROKE	☐
THYROID PROBLEM	☐	RADIATION THERAPY	☐
HIGH/LOW BLOOD PRESSURE	☐	RESPIRATORY PROBLEMS	☐
HEART TROUBLE	☐	BONE DISORDER	☐
EPILEPSY/CONVULSIONS	☐	OSTEOPENIA/OSTEOPOROSIS	☐
ACID RELUX/GERD	☐	REMOVAL OF ADENOIDS/TONSILS	☐

Dental History

DENTIST _____

DATE OF LAST CLEANING _____

	Y	N
1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT?	☐	☐
2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT?	☐	☐
3. DO ANY OF YOUR TEETH CAUSE YOU PAIN?	☐	☐
4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐
IF YES, PLEASE DESCRIBE:		
6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:		
A. CHRONIC CLICKING OR POPPING?	☐	☐
B. PAIN?	☐	☐
C. DIFFICULTY OPENING OR CLOSING?	☐	☐
D. DIFFICULTY CHEWING?	☐	☐
7. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
9. HAVE YOU EVER HAD SPEECH THERAPY?	☐	☐
IF YES, PLEASE DESCRIBE:		
10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED?	☐	☐
IF YES, PLEASE DESCRIBE:		
11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH?	☐	☐
12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:		
A. NAIL BITING?	☐	☐
B. THUMB SUCKING?	☐	☐
C. TONGUE THRUST WHILE SWALLOWING?	☐	☐
D. MOUTH BREATHING?	☐	☐

13. HOW MANY TIMES A DAY DO YOU BRUSH? _____

14. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:

CROWDING	☐	MISSING/EXTRA TEETH	☐
EXTRA SPACE	☐	AIRWAY PROBLEMS	☐
TEETH STICK OUT TOO FAR	☐	TEETH ERUPTING IN THE WRONG POSITION	☐
TMJ PROBLEMS	☐		
POOR BITE RELATIONSHIP	☐	OTHER: _____	

	Y	N
15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE?	☐	☐
IF SO, WHEN AND BY WHOM?		

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE HAMILTON & MANUELE ORTHODONTICS PERMISSION TO PERFORM THE NECESSARY DENTAL SERVICES THAT THE PATIENT MAY NEED.

SIGNATURE OF PATIENT (OR PARENT IF MINOR) _____ DATE _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____

HAMILTON & MANUELE ORTHODONTICS

TELL US ABOUT YOU!

Photo Release

WE WILL BE DOCUMENTING YOUR SMILE TRANSFORMATION WITH PHOTOS, POSSIBLE VIDEOS AND DENTAL MODELS TO CELEBRATE YOUR RESULTS. WE OCCASIONALLY SPOTLIGHT PATIENTS ON OUR WEBSITE, WITHIN THE OFFICE, AND OTHER PRACTICE SITES (FACEBOOK, BLOG, ETC) AND REQUEST YOUR AUTHORIZATION BELOW.

I, THE UNDERSIGNED, DO HEREBY RELINQUISH ANY AND ALL RIGHTS TO PHOTOGRAPHS, PORTRAITS, PRINTS, NEGATIVES, OR OTHER PHOTOGRAPHIC REPRODUCTIONS CAPTURED WITH STILL MOTION PICTURE, VIDEO, DIGITAL OR OTHER CAMERAS FOR USE BY HAMILTON ORTHODONTICS.

PATIENT NAME

PATIENT SIGNATURE

PARENT/GUARDIAN NAME AND SIGNATURE (IF PATIENT IS UNDER THE AGE OF 18)

Acknowledgement of Receipt of Notice of Privacy Practices

*YOU MAY REFUSE TO SIGN THIS AGREEMENT.

I, _____ HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PLEASE PRINT NAME

SIGNATURE

DATE

For Office Use Only

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE;

- ☐ INDIVIDUAL REFUSED TO SIGN
- ☐ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- ☐ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING THE ACKNOWLEDGEMENT
- ☐ OTHER (PLEASE SPECIFY)

DOCTOR SIGNATURE _____ DATE: _____