John W. Haugen, D.D.S.
Specialist in Orthodontics

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Welcome To Our Office.

So that we might become better acquainted, please complete both sides of this form.

Adult Patient Information

Patient's Name ______________________ Preferred Name ______________________ Sex: ________

Home Address ______________________ City ______________________ Zip ____________

Home Phone ______________________ Age ________ Birthday ______________________

Patient's Dentist ______________________ Referred by ______________________

Do you know a patient currently in our practice? If so, Whom ______________________

Who noticed the orthodontic problem ☐ Patient ☐ Dentist ☐ Other ______________________

Please describe your orthodontic problem in your own words ______________________

____

Occupation ____

Employer ______________________ Address ______________________ Wk. Phone ______________________

Social Security # ______________________ E-mail Address ______________________

Would you like to be reminded of upcoming appointments? Y or N

Cell Phone ______________________ Texting Y or N Company name of cell phone provider ____________

Family and Account Information

Spouse's Name ______________________ Employer ______________________ Wk. Phone ______________________

Spouse's Social Security # ______________________

Person responsible for the account ____

If other than self or spouse:

Name ______________________ Occupation ______________________

Address ______________________ City ______________________ Phone ______________________

Dental Insurance Information

Name of Insured (employee) ______________________ Date of Birth ______________________

Name of Insurance Company ______________________ Group # ______________________

ID or Social Security # ______________________

Name of Insured (employee) ______________________ Date of Birth ______________________

Name of Insurance Company ______________________ Group # ______________________

ID or Social Security # ______________________

Medical History

Are you in good health? ☐ No ☐ Yes Explain ____________________

Do you have any history of major illness? ☐ No ☐ Yes Explain ____________________

Have you been under the care of a physician for illness? ☐ No ☐ Yes Explain ____________________

Have tonsils &/or adenoids been removed? ☐ No ☐ Yes If so, at what age? ____________

Do you have frequent colds or ear infection? ☐ No ☐ Yes Explain ____________________

Are you currently taking medication? ☐ No ☐ Yes Please list ____________________

Are you allergic to any medication? ☐ No ☐ Yes Please list ____________________

Please check if you have any of the following conditions:

Condition			Condition		
Hear Murmur/Heart Disorder	____ No	____ Yes	Epilepsy, Seizure	____ No	____ Yes
Joint or Heart Valve Replacement	____ No	____ Yes	Ear Problems	____ No	____ Yes
Rheumatic Fever	____ No	____ Yes	Throat/Nose Problems	____ No	____ Yes
Prolonged Bleeding	____ No	____ Yes	Tonsillitis	____ No	____ Yes
Abnormal Blood Pressure	____ No	____ Yes	Eye Problems/Glaucoma	____ No	____ Yes
AIDS/HIV Infection	____ No	____ Yes	Hormonal Abnormalities	____ No	____ Yes
Diabetes	____ No	____ Yes	Developmental Disorder	____ No	____ Yes
Asthma/Allergies	____ No	____ Yes	Nervous Disorder	____ No	____ Yes
Hepatitis	____ No	____ Yes	Brain Injury/Stroke	____ No	____ Yes
Tuberculosis	____ No	____ Yes	Emotional Problems	____ No	____ Yes

Is there any other condition or problem you think we should know about? ____________________

____

Dental History

When did you last visit the dentist? ____

Is there any unfinished care to be completed with your dentist? ☐ No ☐ Yes Explain ____________

Have you had any face or dental injuries? ☐ No ☐ Yes Explain ____________________

Have you had any previous orthodontic treatment? ☐ No ☐ Yes Explain ____________________

Have you noticed any changes in your bite or dental alignment recently? ☐ No ☐ Yes Explain ________

Is there any other information that may be helpful? ____________________________

I certify the above information to be true to the best of my knowledge.

______________________________ ____________________

Signature Date