WILLIAM R. HATCHER, D.D.S., M.S., P.C
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Please Complete both portions of this form

Diplomates, American Board of Orthodontics

Child Patient Information

Date: ____________________

Last Name: ______________________ First Name: ____________________ Preferred Name: _______________

Address: __________________________ City: ________________________ State: ______ Zip: ____________

Home Phone: ________________________ Birthdate: __________________ Age: _________ Sex: ☐ M ☐ F

Person w/patient today and relationship: ____

Dentist: ___________________________________ Physician: ____

Has any member of your family been a patient of this office before? ☐ Yes ☐ No
Name(s): ____

Who may we thank for recommending our office to you? ____

Brothers/Sisters (names and ages): ____

Hobbies, sports and other extra curricular activities: ____

Family Information

	Father	Mother
Name		
Address (Incl. City/state, zip)		
Home / Cell Phone	/	/
Occupation		
Employer		
Pref. Contact Phone		
E-Mail Address:		

Family Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Responsible Party

Person Responsible for account: ____

Relationship to Patient: _____________________________ Social Security Number: ______________________

Address: ____

City: ____ State: _________ Zip: _________________

Home Phone: ________________ Cell Phone: ________________ Preferred Contact Phone: ________________

Orthodontic Insurance: ☐ Yes ☐ No (if "Yes", fill out form provided)

(OVER)

Medical History

Please check any of the following for which the patient has been treated:

- ☐ Diabetes
- ☐ Pneumonia
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Auto-Immune Disease
- ☐ Vision/Eye Problems
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Asthma
- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ Bone Disorders
- ☐ Endocrine Disorders
- ☐ Heart Murmur
- ☐ Liver or Kidney Problems
- ☐ Emotional Problems
- ☐ Thyroid Problems
- ☐ Fainting or Dizzy Spells
- ☐ Adenoids Removed:Year ____
- ☐ Tonsils Removed:Year _____
- ☐ Stomach Disorders

List any other serious illnesses or medical problems ____

Is the patient presently under the care of a physician? ☐ Yes ☐ No
If yes, please specify conditions ____

List **ALL** Allergies (including those to any drugs, medications, or **METALS**) ____________________

List any drugs/medications now taken ____

Does the patient require antibiotics before dental appointments? ☐ Yes ☐ No

Dental History

	Yes	No
Has the patient ever sucked a thumb or fingers? Until what age? ______	☐	☐
Does the patient have any speech problems?	☐	☐
Does the patient clench or grind the teeth at night?	☐	☐
Does the patient have pain, popping or clicking upon opening and closing the mouth?	☐	☐
Have any teeth been injured or chipped due to accidents?	☐	☐
Have you been informed of any missing permanent teeth?	☐	☐
Have you been informed of any impacted teeth?	☐	☐
Were any permanent teeth removed by extraction?	☐	☐

How many times a year does the dentist examine the patient's teeth? ________________________
Date of last appointment ______________________________

	Yes	No
Has the patient had a previous orthodontic consultation or treatment? . . . . With Whom? ____	☐	☐
Is the patient concerned about the appearance of his/her teeth?	☐	☐
Has the patient reached puberty (girls menstruation/boys voice change)?	☐	☐

What would you like to have orthodontic treatment accomplish? ____

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A credit history may be obtained in order to make financial arrangements.

____
Parent or Guardian Signature