



## WELCOME!

We are pleased to welcome you and your family to our practice.  
Please take a few minutes to fill out this form. If you have questions, we'll be glad to help you.  
Thank you for allowing us to care for you.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City/ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Phone: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_  
 Employer/ School: \_\_\_\_\_ Position/ Grade: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ City Where Dentist Practices: \_\_\_\_\_

### PERSON FINANCIALLY RESPONSIBLE FOR PATIENT

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Address: \_\_\_\_\_ City/ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Phone: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
 SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

- Money Mailer       Internet       Insurance       Yellow Pages  
 Driving by       School Directory       Hashem Orthodontics Promotional Products  
 Dentist       Friend / Patient  
 Other \_\_\_\_\_

### HEALTH HISTORY

	YES	NO
Is the patient in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have Tonsils and Adenoids been removed? .....	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient a mouth breather?.....	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient presently taking any drugs or medications? .....	<input type="checkbox"/>	<input type="checkbox"/>
If any, please list _____		
Does the patient have any <b>ALLERGIES</b> or drug sensitivities? .....	<input type="checkbox"/>	<input type="checkbox"/>
If any, please list _____		
<b>FEMALES ONLY:</b> Are you pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>

### HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE CHECK .

- |  |   |                                       |  |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> HEART MURMUR          | <input type="checkbox"/> RHEUMATIC FEVER                | <input type="checkbox"/> HEART VALVES | <input type="checkbox"/> ARTIFICIAL JOINTS |
| <input type="checkbox"/> HEPATITIS (TYPE ____) | <input type="checkbox"/> HEART PROBLEMS                 | <input type="checkbox"/> DIABETES     | <input type="checkbox"/> ASTHMA            |
| <input type="checkbox"/> TUBERCULOSIS          | <input type="checkbox"/> CONVULSIONS/ SEIZURES          | <input type="checkbox"/> AIDS/ HIV    | <input type="checkbox"/> VENEREAL DISEASE  |
| <input type="checkbox"/> PSYCHIATRIC CARE      | <input type="checkbox"/> OTHER HEALTH CONDITIONS: _____ |                                       |  |

SIGNATURE OF PATIENT

SIGNATURE OF PARENT/ GUARDIAN (FOR MINORS ONLY)

DATE