

Colleyville Office
 5001 Heritage Ave | Suite 100 | 76034
817.283.3000
Smile@HashemOrthodontics.com



Flower Mound Office
 2021 Morriss Rd | Suite 200 | 75028
972.874.8100
Smile@HashemOrthodontics.com

Welcome to Hashem Orthodontics!

We are delighted to welcome you and your family to our practice.
 Please take a few minutes to fill out this form. If you have any questions, we'll be glad to help you.
Thank you for giving us the opportunity to care for your smile!

New Patient Information

Name: _____ Preferred Name: _____ DOB: ____/____/____
 Home Address: _____ City/ State: _____ ZIP: _____
 Phone: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____
 Employer: _____ Occupation: _____
 School: _____ Grade: _____
 SSN: _____ - _____ - _____ Email: _____
 Dentist: _____ City Where Dentist Practices: _____

Person Financially Responsible For Patient

Name: _____ DOB: ____/____/____
 Home Address: _____ City/ State: _____ ZIP: _____
 Phone: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____
 Employer: _____ Occupation: _____
 SSN: _____ - _____ - _____ Email: _____
 Relationship to patient: _____ Secondary Email: _____

How did you hear about us?

Driving by/ Office Sign: _____ Insurance: _____ Hashem Promotional Products/ Event (Please specify): _____
 Internet (Please specify): _____ Friend / Patient (Name & Relationship please): _____
 Dentist (Name please): _____ Other (Please specify): _____

Health History

Is the patient in good health? Yes No
 Have Tonsils and Adenoids been removed? Yes No
 Is the patient presently taking any drugs or medications? Yes No
If any, please list _____
 Does the patient have any ALLERGIES or drug sensitivities? Yes No
If any, please list _____
FEMALES ONLY: Are you pregnant? If so, enter due date: _____ Yes No

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

- HEART MURMUR RHEUMATIC FEVER HEART VALVES ARTIFICIAL JOINTS
- HEPATITIS (TYPE ____)
- TUBERCULOSIS
- PSYCHIATRIC CARE
- HEART PROBLEMS
- CONVULSIONS/ SEIZURES
- OTHER HEALTH CONDITIONS: _____
- DIABETES
- AIDS/ HIV
- ASTHMA
- VENEREAL DISEASE

SIGNATURE OF ADULT PATIENT OR PARENT/ GUARDIAN FOR MINORS

DATE