ENGSTROM HAMILTON ORTHODONTICS

Raleigh | Fuquay Varina
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(919) 870-4443

Patient Information

Today's Date _____ Male ☐ Female ☐

Name _____
Last First MI

Date of Birth _____ Age _____ Common Name _____

Address _____
Street City/State/Zip

Home # _____ Cell # _____ E-Mail _____

Responsible Party Information

Name _____ Relationship to Patient _____
Last First MI

E-Mail _____ Employer/Occupation _____

Home # _____ Cell # _____ Rsp SS # _____

Rsp #2 _____ Relationship to Patient _____
Last First MI

Home # _____ Cell # _____ Rsp SS # _____

E-Mail _____ Employer/Occupation _____

Medical/Dental/Additional Informtion

General Dentist _____ Last Visit Date _____

Is the patient under the care of a physician for a specific problem at this time? _____

Please list all medications (Rx & supplments) _____

List any drug sensitivities or allergies _____

Please check all of the following that apply:

☐ Asthma ☐ Jaw Joint Pain ☐ Teeth Grinding ☐ Hepatitis
☐ Diabetes ☐ Bone Disorders ☐ Heart Condition ☐ AIDS/HIV
☐ Epilespsy ☐ ADD/ADHD ☐ Kidney Problem ☐ Endocrine Problems

Have you been informed about missing /extra teeth? ☐ Yes ☐ No
Has an orthodontist previously been consulted? ☐ Yes ☐ No
Has the patient had any previous orthodontic treatment? ☐ Yes ☐ No
How did you hear about our office? ☐ Dentist ☐ Internet ☐ Family/Friend ☐ Other: _____
What treatment are you interested in? ☐ Braces ☐ Clear Aligners/Invisalign

Select the payment option(s) of interest:
☐ Interest Free Payments ☐ Payment In Full ☐ Low Down-Payment ☐ HSA/FSA

How soon would you like to start treatment? ☐ ASAP ☐ Within the Month ☐ Other: _____

Patient or Authorized Person's Signature

To the best of my knowledge, the above information is true. I understand that it is my responsibility to inform the practice of any changes in medical status.

Signature _____ Date _____