

Personal Information

Last Name		
First Name		
Middle Name		
Address	Street	
	City, State and Zip	
Home Phone		
Date of Birth		
Age		
Social Security Number		
School (If applicable)		
If Patient is a minor, give Parent/Guardian's name		
Whom may we thank for referring you to our office?		

Responsible Party Information

Last Name		
First Name		
Middle Name		
Residential Address:	Street:	
	City, State and Zip	
Mailing Address:	Street	
	City, State and Zip	
How long at this Address	Years	Months
Home Phone		
Work Phone		
Previous Address	Street:	
	City, State and Zip	
Social Security Number:		
Date of Birth:		
Relationship to patient		
Employer		
Occupation		
Number of years employed	Years	Months

Spouse Information

Last Name		
First Name		
Middle Name		
Relationship to patient		
Social Security Number		
Date of Birth		
Employer		
Occupation		
Number of years employed	Years	Months
Work Phone		

Insurance Information

Insured's Name		
Insured's Social Security #		
Insured's ID #		
Insured's Employer		
Insurance Company		
Group Number		
Local Number		
Insurance Company Address	Street	
	City, State and Zip	
Insurance Company Phone Number		
Lifetime or Annual Payable	\$	
Benefit Payable	%	
Deductible	\$	

Emergency Information

Name of nearest relative not living with you		
Address	Street	
	City, State and Zip	
Phone:		

Medical History

Your Physician	
Your Dentist	
Date of Last Visit	
Reason	
Interests	

Medical Information

	Yes	No
Is the patient in good health?		
Has the patient had any history of hay fever, rheumatic fever, hepatitis, high blood pressure, epilepsy, cerebral palsy, heart trouble, allergies, diabetes, asthma, kidney, liver or blood disorders, HIV/AIDS? If so, please specify:		
Any history or current use of tobacco or smoking? If so, please specify:		
Has the patient had an unfavorable reaction to drugs, latex, metals, including antibiotics and local anesthetic solution? If so, please specify:		
Has the patient had surgery? If so, please specify:		
Is the patient presently taking any medication? If so, please specify:		
Please list any musical instruments played:		
1.		
2.		
3.		
Has the patient had any history of thumbsucking, fingersucking, lip-biting, nail-biting, tongue-thrust, clenching or speech problems? If so, please specify:		
Has the patient had an unfavorable experience in a dental or medical office? If so, which office?		
Do you consider the patient to be high-strung or generally nervous?		
Is the patient mentally or emotionally handicapped?		
Is the patient a mouth-breather while awake or asleep?		
Has the patient been informed of any missing or extra permanent teeth?		
Has the patient experienced any problems or pain with the muscles or joints of his jaws?		
Any baby or permanent teeth removed by your dentist?		
Any traumatic injuries to the teeth, face or jaws?		
Has the patient ever been treated for or been told they have periodontal disease (Pyorrhea/gum disease)?		
Has the patient ever been examined by an orthodontist before? If so, when?		
Has the patient ever worn braces or retainers? Describe:		
Has any member of your family received orthodontic treatment? If so, please specify:		
If we have treated a family member or close friend, please name:		
Women - Are you pregnant?		
Do you need to be pre-medicated before any type of dental work?		
If The Patient Is Under 18		
Onset of puberty (boys - voice changed; girls - started menstruation) If YES, when?		

Number and ages of brothers and sisters

Is your child adopted?

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If so, is he/she aware?

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What are your main concerns? How would you like to improve the smile?

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I grant Dr. Haskett permission to use my photos for educational purposes on their website. Initials

I understand that where appropriate, credit bureau reports may be obtained. Initials

If at all possible, it is advised to have a (custodial) parent accompany a child. Our office will call you within two business days to schedule your consultation. We look forward to meeting your family and feel confident you will like our office.