



ERIC D. HANNAPEL, DDS, MS, PC

SPECIALIST IN ORTHODONTICS

6477 Cherry Meadow Dr. SE, Suite 2
Caledonia, MI 49316

tel (616) 891.7272
fax (616) 891.2306

www.hannapelsmiles.com

Comprehensive Patient Registration Record

All Information Listed is
STRICTLY CONFIDENTIAL

PATIENT INFORMATION—CHILD

Patient's Name: _____ Preferred Name: _____
Birthdate: _____ Age: _____ Sex: M F
Address: _____ City/State/Zip: _____
Home Phone: _____ Email: _____
School: _____ Grade Level: _____
Are there other family members that come to our office? _____
Patient's Dentist: _____ Who can we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Parent's Marital Status: _____ Who is patient living with? _____

Father's Information:

Name: _____ Relationship: _____
Date of Birth: _____ Social Security #: _____
Address (if different than above): _____ City/State/Zip: _____
 Own Rent How many years at this address? _____
Home Phone: _____ Cell Phone: _____
Email: _____
Employer: _____ Occupation: _____ # Years Employed: _____
Employer's Address: _____
Work Phone: _____
Orthodontic Insurance: Yes No Company _____

Mother's Information:

Name: _____ Relationship: _____
Date of Birth: _____ Social Security #: _____
Address (if different than above): _____ City/State/Zip: _____
 Own Rent How many years at this address? _____
Home Phone: _____ Cell Phone: _____
Email: _____
Employer: _____ Occupation: _____ # Years Employed: _____
Employer's Address: _____
Work Phone: _____
Orthodontic Insurance: Yes No Company _____

Please list any additional individuals who may obtain information about patient's treatment:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name: _____ Secondary Policy Holder's Name: _____
Relationship to Patient: _____ Relationship to Patient: _____
Insured SS #: _____ Insured SS #: _____
Insured DOB: _____ Insured DOB: _____
Employer Name: _____ Employer Name: _____
Insurance Co. _____ Insurance Co. _____
Subscriber ID #: _____ Subscriber ID #: _____
Group #: _____ Group #: _____

CHILD MEDICAL HISTORY

PLEASE INDICATE WHETHER OR NOT YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS BY CIRCLING (Y)es or (N)o.

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	ADD / ADHD	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	AIDS / Antibody Positive
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Cancer	Y	N	Liver Problems
Y	N	Congenital Heart Defect	Y	N	Lupus
Y	N	Convulsions/Epilepsy	Y	N	Migraine Headaches
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Emotional Problems	Y	N	Sickle Cell Disease/Traits
Y	N	Hearing Impairment	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Tonsils Removed—Age: _____
			Y	N	Adenoids Removed—Age: _____

ALLERGIES: Y N Medications—If yes, please list: _____

Y N Latex Y N Metals Y N Plastic/Acrylic

Is patient currently being seen for any injury or illness? Y or N—If yes, please explain: _____

Are there any other medical concerns we should be aware of? Y or N—If yes, please explain: _____

Does patient need to be pre-medicated prior to dental visits? Y or N—If yes, do you have prescription filled? Y or N

Has the patient reached puberty? GIRLS—Has she started menstruation? Y or N—If yes, approximately when? _____

BOYS—Has his voice changed? Y or N—If yes, approximately when? _____

Name of Physician: _____ Phone: _____

Please list any medication(s) patient is currently taken, along with reason for the medication(s):

CHILD DENTAL HISTORY

When did the patient last visit dentist? _____

Why is the patient seeking an orthodontic consultation? _____

Has the patient had a prior orthodontic consultation or treatment? Y or N—If yes, please explain: _____

Is there a history of a thumb or finger sucking habit? Y or N—If yes, until what age? _____

Does the patient have any speech problems? Y or N—If yes, is patient currently in speech therapy? Y or N

Has the patient ever had a severe head, neck or facial injury? Y or N—If yes, please explain: _____

Does the patient:

Experience frequent headaches? Y or N—If yes, please explain: _____

Pain or clicking in the jaw joint? Y or N—If yes, please explain: _____

Does the patient clench or grind his/her teeth? Y or N—If yes, please explain: _____

Have you been informed of any missing or extra permanent teeth? Y or N—If yes, please explain: _____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform the office of Eric D. Hannapel, DDS, MS, PC of any changes in the patient's medical status. I authorize the team of Eric D. Hannapel, DDS, MS, PC to take x-rays and photos that may be needed during diagnosis and treatment, with my informed consent. The office of Eric D. Hannapel, DDS, MS, PC reserves the right to verify the credit status of potential patients and/or responsible party prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of Parent/Guardian: _____ Today's Date: _____