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SPECIALIST IN ORTHODONTICS

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Comprehensive Patient Registration Record
All Information Listed is
STRICTLY CONFIDENTIAL

PATIENT INFORMATION—ADULT

Patient's Name: _____ Preferred Name: _____

Birthdate: _____ Age: _____ Sex: M F

Address: _____ City/State/Zip: _____

Home Phone: _____ Email: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Are there other family members that come to our office? _____

Dentist Name: _____ Who can we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Social Security #: _____ Birthdate: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Employer: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

PRIMARY Dental Insurance

Orthodontic Coverage? Yes No

Insured's Name: _____

Relationship to Patient: _____

Insured's SS#: _____

Insured's Birthdate: _____

Insured's Employer: _____

Insurance Co. Name: _____

Subscriber ID#: _____

Insurance Co. Group#: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

SECONDARY Dental Insurance

Orthodontic Coverage? Yes No

Insured's Name: _____

Relationship to Patient: _____

Insured's SS#: _____

Insured's Birthdate: _____

Insured's Employer: _____

Insurance Co. Name: _____

Subscriber ID#: _____

Insurance Co. Group#: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

MEDICAL HISTORY

PLEASE INDICATE WHETHER OR NOT YOU HAVE 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	For WOMEN: Are You Pregnant?	Y	N	Adenoids Removed—Age: _____
			Y	N	Mouthbreather

ALLERGIES: Y N Medications—If yes, please list: _____
Y N Latex Y N Metals Y N Plastic/Acrylic

Are you 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: _____

Name of Physician: _____ Phone: _____

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

DENTAL HISTORY

When was your last visit dentist? _____

Why are you seeking an orthodontic consultation? _____

Have you had a prior orthodontic consultation or treatment? Y or N—If yes, please explain: _____

Have you previously been treated for a TMJ problem? Y or N—If yes, please explain: _____

Does your jaw get locked?/Difficulty opening? Y or N—If yes, please explain: _____

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

Do you :

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: _____

I authorize X-rays and Diagnostic Photos to be taken (at no charge) for diagnostic purposes to be able to give you the most accurate information possible at the Initial Examination appointment.

I have read and understand the above questions. I will not hold my orthodontist or any member of his team responsible for any errors or omissions that I have made in the completion of this form. I understand that it is my responsibility to contact this office with any changes in my medical/dental status.

Patient Signature: _____ Today's Date: _____