

# Welcome

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 Specialist in Orthodontics

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## Patient Information

Date: \_\_\_\_\_ Nickname: \_\_\_\_\_ SS #: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ School: \_\_\_\_\_  
 Other Siblings: \_\_\_\_\_ Email: \_\_\_\_\_  
 Who may we thank for referring you?: \_\_\_\_\_

## Responsible Party Information

Who is responsible for the account? \_\_\_\_\_ Patient/Parent  
 Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

<p><u>  </u> <b>Father</b> <u>  </u> <b>Step Father</b> <u>  </u> <b>Guardian</b> <u>  </u> <b>Spouse</b> <u>  </u> <b>Self</b></p> <p>Name: _____          SS#: _____ Date of Birth: _____          Email: _____ Cell Phone: _____          Employer: _____          Occupation: _____          No. of yrs. employed: _____ Work Phone: _____          Address: (if different from patient)          Street: _____          City: _____ State: _____ Zip: _____          How long at residence: _____ Home Phone: _____          Previous Address: (if less than 3 yrs)          Street: _____          City: _____ State: _____ Zip: _____</p>	<p><u>  </u> <b>Mother</b> <u>  </u> <b>Step Mother</b> <u>  </u> <b>Guardian</b> <u>  </u> <b>Spouse</b> <u>  </u> <b>Self</b></p> <p>Name: _____          SS#: _____ Date of Birth: _____          Email: _____ Cell Phone: _____          Employer: _____          Occupation: _____          No. of yrs. employed: _____ Work Phone: _____          Address: (if different from patient)          Street: _____          City: _____ State: _____ Zip: _____          How long at residence: _____ Home Phone: _____          Previous Address: (if less than 3 yrs)          Street: _____          City: _____ State: _____ Zip: _____</p>
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## Dental Insurance Information

Insured's Name: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Do you have dual coverage?: Yes \_\_\_\_\_ No \_\_\_\_\_  
 Secondary Insurance Co: \_\_\_\_\_ Insured: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone: \_\_\_\_\_

## Emergency Information

Emergency contact not living with you: \_\_\_\_\_  
 Complete Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services the patient may need.  
 This office reserves the right to verify the credit status of potential patients and/or parents of patients 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. I understand that I am responsible for payment of services rendered and also responsible for paying any insurance co-payment and deductibles that my insurance does not cover. I hereby authorize the orthodontist to release all information necessary to secure the payment or benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please circle yes or no (if yes, please specify)**

Yes No Are you taking any medications (including for osteoarthritis)? \_\_\_\_\_

Yes No Are you allergic to any medications? \_\_\_\_\_

Yes No Do you have any other allergies? (latex, nickel, metal) \_\_\_\_\_

Yes No Do you have a history of a major illness? \_\_\_\_\_

Yes No Have you had any major operations? \_\_\_\_\_

Yes No Have you ever been involved in a serious accident? \_\_\_\_\_

**Circle any of the medical conditions below that you have had or currently have.**

Abnormal Bleeding	Dizziness	High Blood Pressure	Sleep Apnea
ADD/ADHD	Epilepsy	HIV/Aids	Sleep Disorders
Anemia	Gastrointestinal	Kidney Problems	Tuberculosis
Arthritis	Disorders	Nervous Disorders	Tumor or Cancer
Asthma	Heart Problems	Pneumonia	Back / Shoulder pain
Bone Disorders	Heart Murmur	Prolonged Bleeding	Eye or Ear problems
Congenital Heart Defect	Hepatitis/Liver problems	Radiation/Chemo	Headaches
Diabetes	Herpes	Rheumatic Fever	Osteoarthritis

Yes No Do you require antibiotics prior to any dental treatment?

Yes No Are there any medical conditions that you would like to discuss with the Doctor in private? \_\_\_\_\_

## Dental History

Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

What are your orthodontic concerns? \_\_\_\_\_

How do you feel about receiving orthodontic treatment? \_\_\_\_\_

Yes No Has anyone in your family received orthodontic treatment? If yes, how did they feel about the result? \_\_\_\_\_

Yes No Have you ever seen an orthodontist before? Who and when? \_\_\_\_\_

Yes No Have you always had a favorable dental experience?

Yes No Are you presently in any dental pain?

Yes No Have you ever had any teeth removed?

Yes No Do you have any congenitally missing teeth?

Yes No Do you have extra teeth?

Yes No Have you ever lost or chipped any teeth?

Yes No Have you had your tonsils or adenoids removed?

Yes No Have there been any injuries to the face, mouth or teeth? \_\_\_\_\_

Yes No Is any part of your mouth sensitive to temperature or pressure?

Yes No Do your gums bleed when you brush?

Yes No Do you have any thumb or finger sucking habits?

Yes No Do you have a tongue thrust?

Yes No Are you a mouth breather?

Yes No Do you snore?

Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning?

Yes No Are you aware of your jaw clicking or popping?

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?

Yes No Do you have tension headaches?

**Females Only:**

Yes No Are you pregnant?

Yes No Has menstruation started?

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TC Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Drs. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Review / Update (initial and date): \_\_\_\_\_