Michael Hosier DDS, MS
Hosier ORTHODONTICS

Date _____ **TULSA/MUSKOGEE**

PATIENT INFORMATION

Patient's Name _____ (LAST / FIRST / MI) I Prefer to be called _____ Sex _____

Mailing Address _____ (STREET / CITY / STATE / ZIP) Date of Birth _____ Age _____

E-Mail Address _____ Home Phone _____ Cell Phone/Pager _____

Dentist _____ Family Physician _____ Patient's S.S.# _____

If patient is a minor, give parent's or guardian's name _____ School Attending _____

Whom may we thank for this referral? _____ Hobbies/Interests _____

RESPONSIBLE PARTY INFORMATION

Name _____ (LAST / FIRST / MI) _____ (MARITAL STATUS)

Residence _____ (STREET / CITY / STATE / ZIP)

Mailing Address _____ (STREET / CITY / STATE / ZIP)

How long at this address? _____ Home Phone _____ Work Phone _____

Previous address (if less than three years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Other Parent/Spouse's Name _____ (LAST / FIRST / MI) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Do you have dual coverage? _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____

GROWTH INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Father's Height _____ Mother's Height _____ Adopted? ❒ Yes ❒ No

Patient Resembles ❒ Neither Parent ❒ Mother ❒ Father

Girls: Has she started menstruation? ❒ No ❒ Yes When? _____ Boys: Has his voice changed? ❒ No ❒ Yes When? _____

Names and Ages of Patient's Brothers _____

Names and Ages of Patient's Sisters _____

Family members previously in orthodontic treatment _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone Numbers _____

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

Signature (Parent's signature if minor) _____ Date: _____

Updates (date & initial) _____

A B C

MEDICAL & DENTAL HISTORY

Is the patient in good health? ☐ Yes ☐ No Reason _____
Any major or unusual illnesses? ☐ Yes ☐ No Explain _____
Currently under physician's care? ☐ Yes ☐ No Reason _____
Currently taking medication? ☐ Yes ☐ No List _____
Allergies? Aspirin_____ Nickel_____ Latex_____ Other_____
Drug sensitivity? Codeine_____ Penicillin_____ Erythromycin_____ Other_____

Please Check If Patient Has or Had Any of the Following:

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Heart Disease or Murmur	☐	☐	Frequent Colds or Flu
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Tonsilitis
☐	☐	Prolonged Bleeding	☐	☐	Diabetes	☐	☐	Mononucleosis
☐	☐	Hepatitis	☐	☐	Endocrine Problems	☐	☐	Tonsils Removed: Age: _____
☐	☐	AIDS or HIV positive	☐	☐	Bone Disorders	☐	☐	Adenoids Removed: Age: _____
☐	☐	Jaundice	☐	☐	Epilepsy	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Herpes or Veneral Disease	☐	☐	Mouthbreathing
☐	☐	Malignancies, Tumors, or Cancer	☐	☐	Emotional Stress			

Notes _____

Yes	No	
☐	☐	Has the patient had any severe head or face injuries? Explain _____
☐	☐	Has the patient had a history of thumb sucking or finger sucking? Stopped? _____
☐	☐	Does the patient play any musical (wind) instruments? What? _____
☐	☐	Has the patient consulted an orthodontist previously? Date _____ Doctor _____
☐	☐	Has the patient had any previous orthodontic treatment? Explain _____

PLEASE CHECK YES OR NO FOR THE FOLLOWING QUESTIONS

Yes	No		Yes	No		Yes	No	
☐	☐	Clenching Teeth	☐	☐	High Decay Rate	☐	☐	Jaw Joint Popping/Clicking
☐	☐	Grinding Teeth	☐	☐	Headaches (more than normal)	☐	☐	Ringing in the Ears
☐	☐	Muscular Soreness (head & neck area)	☐	☐	Jaw Joint Soreness	☐	☐	Tongue Thrust
☐	☐	Snoring Loudly	☐	☐	Mouth Breather	☐	☐	Speech Problem/Speech Therapy
☐	☐	Hard Blow to Chin						

When was the patient's last visit with their dentist? _____ Last dental cleaning? _____
What do you or your dentist consider to be your main orthodontic problem? _____
Are there any concerns or other information which might be helpful? _____
Does patient object to braces or any part of orthodontic treatment? _____

(For Office Use Only - Do Not Fill Out Below Line) **TULSA/MUSKOGEE**

Age:	Tulsa Muskogee Dentist	**Class** I II III	**Div** I II
Occ: MR I II III EO UD **CR** I II III EO UD **ML** I II III EO UD **CL** I II III EO UD		**OB**	**OJ**
TMJ R L Pop Click	**Discrepancy:** Mx space mild mod sev Mn space mild mod sev	**Supernumerary** Y N Area	
Frenum: Mx Mn A L	**ML** Mx R L Mn R L	**Diast**: Mx Mn Poss Frenectomy Y	
BO	**Asymmetry : Mx** **Mn**	**Protrusion** Y N Mx Mn Bimax	
Profile	Dental Skeletal	**OH** Excellent Fair Good Poor	

Tx Opt 1	Tx Opt 2	Notes

Missing

Primary

XBite

Impacted

Small

Erupt