

**ORTHODONTIC ACQUAINTANCE INFORMATION**

*Welcome to Our Office*

Date:

Patient’s Name Sex [ ]  Male [ ]  Female

Name Patient prefers to be called Date of Birth Age

Email Address: School Grade

Patient’s Dentist Physician

How did you hear about our office? Whom may we thank for telling you about our office?

**RESPONSIBLE PARTY INFORMATION**

*Please Check* [ ]  Self[ ]  Father [ ]  Step-Father [ ]  Mother [ ]  Step-Mother

Name

Address

City, State, Zip

Home Phone

Business Phone/Cell Phone

Email Address

Occupation

Parent’s Marital Status [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed [ ]  Single

**MEDICAL HISTORY**

Is the patient in good health? [ ]  Yes [ ]  No Explain

Any major or unusual illnesses? [ ]  Yes [ ]  No Explain

Currently under physician’s care? [ ]  Yes [ ]  No Explain

Currently taking medication? [ ]  Yes [ ]  No List

Any allergies or drug sensitivity? [ ]  Yes [ ]  No List

Any latex allergy? [ ]  Yes [ ]  No

Do you need prophylactic antibiotic coverage prior to dental procedures? [ ]  Yes [ ]  No For What Reason?

Have you ever taken Bisphosphonate medications (Examples: Fosamax, Boniva, Actonel) ? [ ]  Yes [ ]  No For How Long?

**PLEASE CHECK THE FOLLOWING AS THEY APPLY**

[ ]  Speech Problems [ ]  Hearing Disorder [ ]  Autism [ ]  Diabetes

[ ]  Glaucoma [ ]  Nervous Disorder [ ]  ADHD/ADD [ ]  Bleeding Problems

[ ]  Heart Trouble [ ]  High Blood Pressure [ ]  Emotional Problems [ ]  Kidney Disease

[ ]  Head or Facial Injury [ ]  HIV/AIDS [ ]  Epilepsy [ ]  Endocrine Problems

[ ]  Hepatitis [ ]  Liver Disease [ ]  Allergies or Asthma [ ]  Other

*(For Patients under age 18)*

Has the patient reached puberty? [ ]  Yes [ ]  No Notes Regarding Above Conditions:

Has there been a drastic change in shoe size recently? [ ]  Yes [ ]  No

**Females**: Has the patient started menstruation? [ ]  Yes [ ]  No If yes, what age?

**Males:** Has the patient’s voice changed? [ ]  Yes [ ]  No If yes, what age?

**DENTAL HISTORY**

Has there been any injuries to the face, mouth or teeth? [ ]  Yes [ ]  No If so, explain

Is there presently a thumb sucking or finger sucking habit? [ ]  Yes [ ]  No

Has the patient consulted an orthodontist previously? [ ]  Yes [ ]  No If so, what office?

Has the patient had orthodontic treatment previously? [ ]  Yes [ ]  No If so, by whom?

Please list any family members treated here

What part of your child’s orthodontic problem concerns you the most?

**INSURANCE INFORMATION**

Insurance Company: Insurance Phone #:

Claims Mailing Address: City: State: Zip:

Subscriber Name: Subscriber ID: Group:

Subscriber Date of Birth: Subscriber Social Security #: Employer:

**privacy notice:** Our office has privacy policies that describe how medical information about you may be used & disclosed. Our complete privacy policy is available at our office for review & at our website, [www.smilesbyharris.com](http://www.smilesbyharris.com). By signing below, you agree to comply with our policy and understand your rights associated with your personal protected health information.

**Communication with Dentists/specialists:** As noted above, our office has privacy policies that describe how medical information about you may be used & disclosed. By signing below you are authorizing our office to share radiographs and treatment information with your dentist and any other specialist we refer you to for additional treatment.

**Signature** Date

*Privacy Policy*

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