

**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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