ORTHODONTIC ACQUAINTANCE INFORMATION

Welcome to Our Office

HARRIS ORTHODONTICS
EXCEPTIONAL CARE • EXCEPTIONAL RESULTS

Member American Association of Orthodontists
My Life. My Smile. My Orthodontist.

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		
Employer		

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 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

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? _____

Notes Regarding Above Conditions: _____

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. 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 _____