HARMONY
ORTHODONTICS

CHILD PATIENT INFORMATION

Today's Date _____

Child's Name: _____ (LAST) _____ (FIRST) _____ (Nick Name) Birth Date _____

Residence _____

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

Parent's Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) Email: _____

How long at this address _____ Home Phone _____

Parent's Employer _____ Occupation _____ No. Years Employed _____

Parents's Birth Date _____ Parents's Cell _____

Previous address(if less than 3 years) _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

◯ Rent ◯ Own

Parent's #2 Name _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Parent's #2 Employer _____ Parent's #2 Occupation _____ Parent's #2 No. Years Employed _____

Parents's #2 Birth Date _____ Parents's #2 Cell _____

INSURANCE INFORMATION

Policy Holder's Name _____ DOB: _____ Soc. Sec. # _____

Policy Holder's Address (if different) _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Insurance Company: _____ Group # _____ ID # _____

Insurance Co. Address: _____

Do you have dual coverage? ◯ Yes ◯ No If Yes, please continue: _____

Policy Holder's Name _____ DOB: _____ Soc. Sec. # _____

Insurance Company: _____ Group # _____ ID # _____

Insurance Co. Address: _____

Employer: _____

EMERGENCY CONTACT

Name _____

Phone: _____ Relationship to Patient: _____

Signature

Date: _____

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

PATIENT MEDICAL HISTORY

Physician's Name _____ Aprroximate date of last physical exam _____

Has patient ever been under extended care of a physician? ◯ Yes ◯ No If yes, please explain _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Anemia	☐ Excessive Bleeding	☐ Pain in Jaw Joint
☐ Asthma	☐ Heart Problems	☐ Rheumatic Fever
☐ Cold Sores or Fever Blisters	☐ Hepatitis	☐ Anxiety
☐ Diabetes	☐ HIV Positve (AIDS)	☐ ADD/ADHD
☐ Depression	☐ Nervous Disorders	☐ Tuberculosis
☐ Endocrine Problems	☐ Autism Spectrum	☐ Other

Does patient gag easily? ◯ Yes ◯ No

Does patient have special needs? ◯ Yes ◯ No Explain _____

Does patient have frequent ear infections? ◯ Yes ◯ No

Have tonsils and adenoids been removed? ◯ Yes ◯ No At what age? _____

Women: Are you pregnant? ◯ Yes ◯ No

Are medications now being taken? ◯ Yes ◯ No Please list what type of medication and why? _____

Does patient have any allergies: ◯ Yes ◯ No If yes. please list: _____

Foods, medications. environmental (ie.. hay fever)

PATIENT DENTAL HISTORY

Dentist Name: _____ Approximate date of last dental exam _____

Have there ever been any injuries to the face, mouth, or teeth? ◯ Yes ◯ No _____

Has patient ever sucked their fingers or thumb? ◯ Yes ◯ No Until what age? _____

Does patient have any speech problems? ◯ Yes ◯ No _____

Is patient a mouth breather while asleep? ◯ Yes ◯ No

Is patient a mouth breather while awake? ◯ Yes ◯ No

Have you been informed of any extra or missing permanent teeth? ◯ Yes ◯ No _____

Has patient ever had a previous orthodontic exam? ◯ Yes ◯ No _____

Have any family members had orthodontic treatment? ◯ Yes ◯ No _____

Is there pain in the jaw joint? If yes ◯ Right ◯ Left When did this begin _____

Is there any popping or cracking of the jaw joint? If yes ◯ Right ◯ Left When did this begin _____

Does patient clench or grind? If yes ◯ Night ◯ Day When did this begin _____

Does patient have headaches? ◯ Yes ◯ No

Frequency _____ Location _____

What is the chief concern that brought you to our office? _____