HARMONY
ORTHODONTICS

Date: _______________

Adult Patient Information

Patient name: ______________________ ________________________ ______ ______________________ ______________
Last First M.I. Preferred name (Preferred Pronoun)

DOB: _________________ Social Security Number: __________________ Marital status: ◯ Single ◯ Married ◯ Divorced

How did you hear about our office? ____

Cell phone: ___________________ Home phone: ___________________ Email: ____________________________________

Residence address: ____
Street City State Zip

◯ Rent ◯ Own No. of years at this address? ______ Previous address: ______________________________________
*if less than three years

Mailing address: ____
*if different from above

Employer: ____________________________ Occupation: ____________________________ No. years employed? ________

Spouse Information

(If applicable)

Spouse's name: __________________________ ___________________________ ________ __________________________
Last First M.I. Preferred name

DOB: ____________________ Social Security Number: ____________________ Cell phone: __________________________

Residence Address: ____
*if different from above

Employer: ____________________________ Occupation: ____________________________ No. years employed? ________

Insurance Information

Policy holder's name: _________________________________ DOB: _____________________ SSN: ____________________
Address (if different than above): ____
Insurance Co. name: ___________________________ ID No. _______________________ Group No.__________________
Insurance Co. phone No. ____________________ Claims address: ____

Do you have dual coverage? If yes, please continue:

Policy holder's name: _________________________________ DOB: _____________________ SSN: ____________________
Address (if different than above): ____
Insurance Co. name: ___________________________ ID No. _______________________ Group No.__________________
Insurance Co. phone No. ____________________ Claims address: ____

Emergency Contact Information

Name: ___________________________ **Phone:** _________________________ **Relationship to patient:** ________________________

SIGNATURE: **DATE**:

X

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

Patient Medical History

Physician's name: ______________________________ Approximate date of last physical exam: ______________________

Has the patient ever been under extended care of a physician? ○ Yes ○ No (if yes, please explain below):

____

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

○ Anemia
○ Asthma
○ Cold sores/Fever blisters
○ Diabetes
○ Depression
○ Endocrine problems
○ Excessive bleeding
○ Heart problems
○ Hepatitis
○ HIV positive (AIDS)
○ Nervous disorders
○ Autism spectrum
○ Pain in jaw joint(s)
○ Rheumatic fever
○ Anxiety
○ ADD/ADHD
○ Tuberculosis
○ Other: ______________________

Does patient need to be medicated prior to dental appointments? ○ Yes ○ No (if yes, please explain):

____

Does patient gag easily? ○ Yes ○ No

Does patient have special needs? ○ Yes ○ No (if yes, please explain):

____

Does patient have frequent ear infections? ○ Yes ○ No

Have tonsils and adenoids been removed? ○ Yes ○ No

Women: Are you pregnant? ○ Yes ○ No

Are any medications currently being taken? ○ Yes ○ No (If yes, please list and explain):

____

Does patient have any allergies? ○ Yes ○ No (if yes, please list):

____

*foods, medications, environmental (i.e... hay fever)

PATIENT DENTAL HISTORY

General Dentist (name or name of office): __________________________ Approximate date of last cleaning: __________

Is there any dental work to be completed? (fillings, crowns, etc.) ○ Yes ○ No __________________________________
Have there been any injuries to the face, mouth, or teeth? ○ Yes ○ No __________________________________
Have you ever sucked your fingers or thumb? ○ Yes ○ No Until what age? _________________
Does patient have any speech problems? ○ Yes ○ No __________________________________
Have you ever had orthodontic treatment? ○ Yes ○ No __________________________________
Have any family members had orthodontic treatment? ○ Yes ○ No __________________________________
Are you a mouth breather? ○ Yes ○ No
Have you been informed of extra or missing permanent teeth? ○ Yes ○ No
Is there pain in the jaw? ○ Yes ○ No Right, Left, or Both? _______________
Is there popping or clicking in the jaw joint(s)? ○ Yes ○ No Right, Left, or Both? _______________
Does you clench or grind? ○ Yes ○ No
Does you regularly experience headaches? ○ Yes ○ No How often? _____________________

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