HARNICK Orthodontics

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WELCOME TO OUR OFFICE

Date _____

Patient's Name _____ ❑ Male ❑ Female
First M.I. Last

Nickname (optional) _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Phone # _____ Preferred type of contact: circle one: Call / Text / Email Appt Reminder : Email [ ]Y [ ]N
Text [ ]Y [ ]N

E-mail (Strictly Confidential) _____

Parent Name(s) _____ Who does child live with _____

Whom may we thank for referring you? (Dentist &/or Friend) _____

Name & Ages of Siblings _____ School _____

Special Interests/Hobbies _____

Name of friend or relative not living with you _____ Phone # _____

Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship _____ Phone # _____
First M.I. Last

Address _____ City _____ State _____ Zip Code _____

Social Security _____ Drivers License # _____ Birthdate _____

Employer's Name _____ Phone # _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____

Orthodontic Insurance Information

Primary orthodontic insurance

Insured's Name: _____ Relation _____ Birthdate: _____

Insurance Co. Name: _____ Phone number: _____

Address: _____ City/State: _____ Zip _____

Employer Name: _____ Group # _____ ID # _____

Secondary orthodontic insurance Do you have dual coverage? [ ]Y [ ]N

Insured's Name: _____ Relation _____ Birthdate: _____

Insurance Co. Name: _____ Phone number: _____

Address: _____ City/State: _____ Zip _____

Employer Name: _____ Group # _____ ID # _____

*Please give your insurance card(s) to the receptionist to run a photocopy.

PLEASE COMPLETE MEDICAL HISTORY ON BACK → -OVER-

MEDICAL HISTORY

Physician Name _____ **Last Medical Exam** _____

Address _____ **Phone #** _____

If currently under the care of physician, for what reason? _____

If taking any medications now, What? _____

For what purpose? _____

Any serious illness or operations? _____

Allergic to: ❑ **Penicillin** ❑ **Codeine** ❑ **Local Anesthetic Injections** ❑ **Other** _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (*PLEASE* indicate Yes or No for EACH item)

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease	❑	❑	Tuberculosis or Lung Disease	❑	❑	Frequent Headaches	❑	❑	Anemia
❑	❑	Abnormal Blood Pressure	❑	❑	Diabetes	❑	❑	Cancer or Leukemia	❑	❑	Pacemaker
❑	❑	Rheumatic Fever	❑	❑	Epilepsy	❑	❑	Radiation Therapy	❑	❑	Prolonged Bleeding
❑	❑	Congenital Heart Lesions	❑	❑	Venereal Disease	❑	❑	Asthma or Other Breathing Problems	❑	❑	Herpes
❑	❑	Heart Murmur	❑	❑	Hepatitis or Liver Problems	❑	❑	Glaucoma	❑	❑	Arthritis
❑	❑	Stroke	❑	❑	Jaundice	❑	❑	Immune Disorder	❑	❑	Sinus Trouble or Hay Fever
❑	❑	Ulcers	❑	❑	Nervous Disorder	❑	❑	Growth Disorder	❑	❑	Allergy to Medication
						❑	❑	HIV	❑	❑	Sleep Apnea

If yes, explain _____

DENTAL HISTORY

General Dentist _____ Date of last cleaning and check up? _____

Is there any dental pain at this time_____

PLEASE CHECK BOX IF YOU HAVE HAD OR NOTICE ANY OF THE FOLLOWING

- ❑ Teeth Sensitive to Hot, Cold, Sweets or Pressure
- ❑ Traumatic injury to teeth or mouth
- ❑ Emergency treatment required
- ❑ Pain or Tenderness around Ear, Joint or Side of Face
- ❑ Difficulty in: ❑Opening ❑Closing ❑Chewing
- ❑ Clicking or Popping of Jaw Joint
- ❑ TMJ Treatment

Oral Habits:

- ❑ Smoking/Tobacco use
- ❑ Thumb Sucking ❑Fingernail or ❑Cheek Biting
- ❑ Clenching of Grinding of Teeth ❑ Day ❑ Night
- ❑ Periodontal Treatment (Gum)
- ❑ Loosening of your teeth
- ❑ Extractions

- ❑ Pain and/or swelling of gums
- ❑ Bleeding of gums when brushing
- ❑ Mouth breathing
- ❑ Tonsils or adenoids removed
- ❑ Missing teeth
- ❑ Additional teeth

If yes, explain _____

ORTHODONTIC HISTORY

Are you satisfied with the appearance of your teeth? _____

Are you interested in (circle): (1) Traditional Braces (2) Clear Braces (3) Invisalign (4) Sleep Apnea Appliance

**In your own words, please describe what you feel is wrong with your teeth or bite.* _____

_____

Have you had other orthodontic treatment? ❑ Yes ❑ No When? _____

Have you had other orthodontic consultations? ❑ Yes ❑ No When? _____

Has any member of your family had orthodontic treatment? ❑ Yes ❑ No When? _____

Please answer the following questions:

Fathers height:_____ Mothers Height:_____The patients teeth most resemble [Father] [Mother]

Female Patients only: Has patient started a menstrual cycle? ❑ Yes ❑ No When? _____ Pregnant ❑ Yes ❑ No

Signature _____ Date _____ Reviewed _____