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NE Albuquerque, NM 87111
505.323.0500

David J Harnick DDS, MSD Kari S. Harnick, DDS, MS

Welcome to our office

Date _____ Mr. Mrs. Ms. Miss Dr. Patient's Name _____

Male Female Nickname (optional) _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Phone # _____ Daytime Phone # to confirm appts.# _____ Ask for _____

E-mail (strictly confidential) _____

May We Email Or Text An Appt Reminder? Email Y N Text Y N

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

Special Interests/Hobbies _____

Name of a friend or relative not living with you _____

Address _____ City _____ State _____ Zip Code _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship _____ Phone # _____

Address _____ City _____ State _____ Zip Code _____

Social Security _____ Drivers License # _____ Birthdate _____

Employer's Name _____ Phone # _____ Occupation _____

Position _____ Length of Employment _____

Are you covered under an orthodontic insurance plan? Yes No

ORTHODONTIC INSURANCE INFORMATION

PRIMARY ORTHODONTIC INSURANCE

Insured's Name _____ Relation _____ Birthdate _____

Insurance Co. Name _____ Phone number _____

Address _____ City _____ State _____ Zip Code _____

Employer Name _____ Group # _____ ID # _____

SECONDARY ORTHODONTIC INSURANCE

Insured's Name _____ Relation _____ Birthdate _____

Insurance Co. Name _____ Phone number _____

Address _____ City _____ State _____ Zip Code _____

Employer Name _____ Group # _____ ID # _____

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

MEDICAL HISTORY

Physician Name _____ Last Medical Exam _____

Address _____ Phone # _____

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

If taking any medication now, What? _____

For what purposes? _____

Have you had any serious illness or operations? _____

Are you allergic to: Penicillin Codeine Local Anesthetic Injections Other _____

Women: If pregnant, how far along are you? _____

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 |
|--|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Asthma or other | <input type="checkbox"/> <input type="checkbox"/> Herpes |
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> beathing Problems | <input type="checkbox"/> <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Liver Problems | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble or Hay Fever |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> <input type="checkbox"/> Jaundice | <input type="checkbox"/> <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> <input type="checkbox"/> Allergy or Medication |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> <input type="checkbox"/> Growth Disorder | <input type="checkbox"/> <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> <input type="checkbox"/> HIV | |
| <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> Cancer or Leukemia | <input type="checkbox"/> <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> <input type="checkbox"/> Tuberculosis or Lung Disease | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | |
| | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> <input type="checkbox"/> Prolonged Bleeding | |

If yes, explain _____

DENTAL HISTORY

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

Are you having any dental pain at this time? _____

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Teeth Sensitive to Hot, Cold, Sweets or Pressure | <input type="checkbox"/> Traumatic injury to teeth or mouth | <input type="checkbox"/> Pain or Tenderness around Ear, Joint or Side of Face | <input type="checkbox"/> Difficulty in:
○ Opening
○ Closing
○ Chewing |
| <input type="checkbox"/> TMJ Treatment | <input type="checkbox"/> Clicking or Popping Jaw | | |

ORAL HABITS:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Smoking/Tobacco use | <input type="checkbox"/> Clinching of Grinding of Teeth
○ Day ○ Night | <input type="checkbox"/> Pain and/or swelling of gums | <input type="checkbox"/> Tonsils or adenoids removed |
| <input type="checkbox"/> Thumb Sucking | <input type="checkbox"/> Loosening of your teeth | <input type="checkbox"/> Bleeding of gums when brushing | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Fingernail/Cheek Biting | <input type="checkbox"/> Extractions | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Additional teeth |
| <input type="checkbox"/> Periodontal Treatment (Gum) | | | |

If yes, explain _____

ORTHODONTIC HISTORY

Are you satisfied with the appearance of your teeth? _____

Are you interested in Traditional Braces Clear Braces Invisalign 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? _____

Signature _____ Date _____ Reviewed _____