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Albuquerque, NM 87114
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10425 Montgomery Pkwy
NE Albuquerque, NM 87111
505.323.0500

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

Welcome to our office

Date _____ 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) _____ Preferred type of contact Call Text Email

Appt Reminder: Email Y N Text Y N

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

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

Special Interests/Hobbies _____

Name & Ages of Siblings _____ School _____

Name of 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 _____

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? _____

Any serious illness or operations? _____

Allergic to: Penicillin Codeine Local Anesthetic Injections Other _____

DO YOU HAVE OR 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"/> Clenching 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? _____

Please answer the following questions

Father's height _____ Mother's 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 _____