8631 Golf Course NW, Ste F
Albuquerque, NM 87114
505.831.1600

HARNICK
Orthodontics

10425 Montgomery Pkwy
NE Albuquerque, NM 87111
505.323.0500

David Harnick, DDS, MSD, Kari Harnick Graeber, DDS, MS

Welcome to our office

Date _____ Patient's Name _____ ☐ Male ☐ Female ☐ Non-Binary ☐ None of the above ☐ Identify as _____

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	
☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐	Asthma or other beathing Problems	☐	☐	Herpes
☐	☐	Abnormal Blood Pressure	☐	☐	Epilepsy	☐	☐	Glaucoma	☐	☐	Arthiritis
☐	☐	Rheumatic Fever	☐	☐	Hepatitis or Liver Problems	☐	☐	Immune Disorder	☐	☐	Sinus Trouble or Hay Fever
☐	☐	Congenital Heart Lesions	☐	☐	Jaundice	☐	☐	Growth Disorder	☐	☐	Allergy or Medication
☐	☐	Heart Murmur	☐	☐	Nervous Disorder	☐	☐	HIV	☐	☐	Sleep Apnea
☐	☐	Stroke	☐	☐	Frequent Headaches	☐	☐	Anemia			
☐	☐	Ulcers	☐	☐	Cancer or Leukemia	☐	☐	Pacemaker			
☐	☐	Tuberculosis or Lung Disease	☐	☐	Radiation Therapy	☐	☐	Prolonged Bleeding			
			☐	☐	Venereal Disease						

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

☐ Teeth Sensitive to Hot, Cold, Sweets or Pressure
☐ TMJ Treatment

☐ Traumatic injury to teeth or mouth
☐ Clicking or Popping Jaw

☐ Pain or Tenderness around Ear, Joint or Side of Face

☐ Difficulty in:
- ○ Opening
- ○ Closing
- ○ Chewing

ORAL HABITS

☐ Smoking/Tobacco use
☐ Thumb Sucking
☐ Fingernail/Cheek Biting
☐ Periodontal Treatment (Gum)

☐ Clinching of Grinding of Teeth ○ Day ○ Night
☐ 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 ☐ 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 _____