HARRIS ORTHODONTICS

Patient Information Date_____
Name_____ Nickname:_____ Birthdate_____
Address_____ Social Security #_____
City_____ State_____ Zip Code_____ Phone_____

Email_____
Driver's License #_____
Employer:_____ Occupation:_____
Employer Address_____Work Phone_____

Spouse's Name_____ Birthdate_____
Social Security #_____ Driver's License #_____
Employer_____ Occupation_____
Employer Address_____ Work Phone_____

Medical/Dental History

Family Dentist _____
Date of last dental exam_____
Primary concern regarding tooth alignment?
_____
Habits: Thumb/Finger Sucking___ Grinding/Clenching Teeth___
Mouth Breathing___ Lip/Cheek Biting___
Have you ever received any orthodontic treatment?____Orthodontist's name_____
Has anyone in your family ever been a patient in our office?_____
Jaw joint noise or discomfort?____

Patient's Physician_____
Check any of the medical conditions, which apply:

__Asthma	__Heart Problems	__Hepatitis
__Chronic Sinus	__Rheumatic Fever	__Diabetes
__Freq. Colds	__Blood Disease	__Seizures
__Freq. Headaches	__A.I.D.S.	__Hormonal Problems

Tonsils Removed____ Age___ Adenoids Removed___ Age___
Other physical or mental considerations?
_____
Osteoporosis medication being taken?_____
Drugs or Medications being taken/reasons
_____
Injuries to head, face or
teeth_____

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