HARMONY
ORTHODONTICS

Patient Information Form

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Gender: _____ Date of Birth: _____ Age: _____

Email: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

School: _____ Grade: _____

Who else have we treated in your family? _____

How did you hear about our office or who referred you? _____

Responsible Party: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Spouse or Other Parent: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Primary Dental Insurance

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone #_____

Member ID#_____ Group #_____ Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone #_____

Member ID#_____ Group #_____ Insured's Employer: _____

Consent to Exam

I understand that a pre-treatment exam and records are necessary before an orthodontist can make any specific treatment recommendations for my care. Pre-treatment records include a panoramic x-ray, facial and intra-oral digital photographs and a digital scan. I hereby consent to this complete orthodontic examination and to the taking of any necessary pretreatment records.

Name: _____ Signature: _____ Date: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Confidential Patient Health History

Medical History

Primary Physician: _____ Phone: _____ Approximate date of last dental cleaning: _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Please confirm whether or not the patient has been treated for any of the following:

☐ Yes ☐ No Heart Conditions (murmur, etc.)	☐ Yes ☐ No HIV Positive	☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Excessive Bleeding	☐ Yes ☐ No Tuberculosis	☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Asthma	☐ Yes ☐ No Kidney Infections
☐ Yes ☐ No Rheumatic Fever	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Cerebral Palsy
☐ Yes ☐ No Liver Problems	☐ Yes ☐ No Birth Defects	☐ Yes ☐ No Eyesight Problems
☐ Yes ☐ No Cancer	☐ Yes ☐ No Infections	☐ Yes ☐ No Speech Impairments
☐ Yes ☐ No Nervous Disorders	☐ Yes ☐ No ADHD	☐ Yes ☐ No Autism
☐ Yes ☐ No Other_____		

Is the patient currently on any medications? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any foods or medicines? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any plastics or metals? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient taking or has the patient taken Bisphosphonates (e.g. Fosomax)? ..... ☐ Yes ☐ No

Does the patient need to be medicated prior to dental appointments? ..... ☐ Yes ☐ No

Have tonsils or adenoids been removed? ..... ☐ Yes ☐ No

Are you pregnant? ..... ☐ Yes ☐ No

Dental and Orthodontic History

General Dentist (name of office): _____ Approximate date of last dental cleaning _____

Is there any dental work to be completed? (Fillings,crowns, etc.). ☐ Yes ☐ No _____

Have there been any injuries to the face, mouth, or teeth? ☐ Yes ☐ No _____

Has the patient ever sucked their fingers or thumb? ☐ Yes ☐ No Until what age? _____

Does the patient have any speech problems? ☐ Yes ☐ No _____

Is the patient a mouth breather while asleep or awake? ☐ Yes ☐ No _____

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No _____

Is there pain/popping/clicking in the jaw joint? ☐ Yes ☐ No When did this begin? _____

Does the patient clench or grind? ☐ Yes ☐ No _____

Does the patient regularly have headaches? ☐ Yes ☐ No _____

Does the patient gag easily? ☐ Yes ☐ No _____

Has the patient ever had orthodontic treatment? ☐ Yes ☐ No _____

Has the patient ever had a previous orthodontist exam? ☐ Yes ☐ No _____

Have any family members had orthodontic treatment? ☐ Yes ☐ No _____

What is the chief concern that brought you to our office? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Health History Update

Patient Initial: _____ Date: _____

Doctor: _____ Date: _____