HARRIS ORTHODONTICS

Patient Information Date_____
Name_____ Nickname:_____ Birthdate _____
Address_____ Social Security #_____
City_____State_____ Zip Code_____ Phone_____

Responsible Party Information
Name_____ Birthdate_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Email_____
Social Security #_____ Driver's License #_____
Relationship to patient:_____
Employer:_____ Occupation:_____
Employer Address_____

Spouse's Name_____ Birthdate_____
Social Security #_____ Driver's License #_____
Relationship to patient_____
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___
Has patient received any orthodontic treatment?____ Orthodontist's name_____
Has anyone in your family ever been a patient in our office?_____
Did Father have orthodontic treatment?___ Age___ Dr._____
Did Mother have orthodontic treatment?___ Age___ Dr._____
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?_____
Drugs or Medications being taken/reasons _____
Injuries to head, face or teeth_____
Has patient reached puberty?_____ Speech problem___ What sounds?_____
Is patient adopted? _____

154 McGREGOR ROAD • DeLAND, FL 32720 • TEL (386) 736-9966 • FAX (386) 822-9959
www.drharrisortho.com