Adult

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions we will be glad to help you. Please print the following information on the patient to be examined. Thank you. **HarrisonBraces.com** **InBraces.com**

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Patient Information

Full Name____________________________________**DOB** ____/____/_____ **Male / Female**

Address____
Street

____**Home phone#**____________________
City **State** **Zip**

S.S.#_________/______/_________ **In case of emergency, who should we contact?** __________________

____ **Phone #**__________________________

Your Employer______________________________________**Work phone #**______________________

Spouse's Name _______________________________________ **S.S.#**__________/______/____________

Who will be responsible for this account?____

Do you have any immediate family members presently in treatment here or who have had previous treatment in this office? Names ____

Do you have dental insurance? Yes / No ____

Medical Information

Name of Physician____

Are you allergic to anything (including penicillin)?____

Do you have any of the following medical problems? (if yes, please circle) ASTHMA BLEEDING CLEFT PALATE HAY FEVER HEART MURMUR HEPATITIS DIABETES ALLERGIES RHEUMATIC FEVER HIV Positive

Are you taking any medication of any type at this time? (please list)__________________________________

____

Is there any medical information that should be brought to our attention?________________________

____

Dental History

Name of Dentist____

Who referred you to this office? (dentist, hygienist, friend, phonebook, etc.)____________________

____

What concerns you most about your teeth?

____

____

Have you ever injured your teeth or jaws? (any falls, bumps, etc.)

____

____

Have you ever seen an orthodontist? If yes, who and when (approx.)___________________________

____

Do you have any problems breathing through your nose?______**If yes, is this allergy related?**______
Do you snore at night? Yes / No Do you grind or clinch your teeth? Yes / No
If Yes, when?____

When you open and close your mouth is there any clicking or pain? Pain / Clicking / Both

Is there any other dental information that should be brought to our attention?__________________

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Authorization

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, and in general dental health. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name (or my child's) may be used for educational and promotional purposes. The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in the patient's medical or dental status.

Signature of patient, parent or legal guardian____

Date______/______/_20_______