

# 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 \_\_\_\_\_

Nickname ( likes to be called) \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male / Female

Address \_\_\_\_\_  
Street City State Zip

Mother's name \_\_\_\_\_ S.S.# \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address (if different) \_\_\_\_\_

Phone (home) \_\_\_\_\_ (business) \_\_\_\_\_

Employer \_\_\_\_\_

Father's name \_\_\_\_\_ S.S.# \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address (if different) \_\_\_\_\_

Phone (home) \_\_\_\_\_ (business) \_\_\_\_\_

Employer \_\_\_\_\_

Parents are married, divorced, separated, widowed (please circle)

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

Name(s) \_\_\_\_\_

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 clench 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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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\_\_\_\_