HARNER ORTHODONTICS

PATIENT INFORMATION (CHILD)

PATIENT INFORMATION

First Name: _____ Last Name: _____

Nickname: _____ Birth Date: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Who is filling in this form? Print Full Name: _____

Relationship to patient: _____

General Dentist _____ Phone: _____

How did you hear about us? _____

Has the patient visited an orthodontist before? ◯ YES ◯ NO

If yes, for what reason? _____

Have we treated another family member? ◯ YES Name: _____ ◯ NO

What are the main concerns that you would like orthodontics to accomplish? _____

PARENT/GUARDIAN INFORMATION

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

◯ **Father** ◯ **Stepfather** ◯ **Guardian** Full Name: _____

Address (If different from patient) _____ Birth Date: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

If you have insurance coverage for the child, please fill this section out:

Insurance Name: _____

Member ID or Social Security: _____ Group: _____

◯ **Mother** ◯ **Stepmother** ◯ **Guardian** Full Name: _____

Address (If different from patient) _____ Birth Date: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

If you have insurance coverage for the child, please fill this section out:

Insurance Name: _____

Member ID or Social Security: _____ Group: _____

DENTAL AND MEDICAL HISTORY

Is the child currently under the care of a physician? ◯ Yes ◯ No If yes, for what reason? _____

Child's Physician: _____ Phone: _____

History of major illness? ◯ Yes ◯ No If yes, please describe: _____

Any sensitivities/allergies? ◯ Yes ◯ No If yes, please list: _____

Currently taking medications? ◯ Yes ◯ No If yes, please list: _____

Has puberty began? ◯ Yes ◯ No Has menstruation began? ◯ Yes ◯ No ◯ Not applicable

Has the patient ever been treated for any of the following medical concerns?

◯ Abdominal Bleeding
◯ Arthritis
◯ Asthma
◯ Cancer/Chemotherapy
◯ Diabetes
◯ Epilepsy/Seizures/Falling
◯ Heart Condition
◯ High Blood Pressure
◯ Nervous Disorder
◯ Osteoporosis
◯ Tuberculosis
◯ No Medical Concern

Is the patient allergic to any of the following?

◯ Aspirin
◯ Codeine
◯ Dental Anesthetics
◯ Erythromycin
◯ Latex
◯ Any Metal/Plastics
◯ Penicillin
◯ Tetracycline
◯ Other: _____
_____
_____

Do you require antibiotics before dental treatments? ◯ Yes ◯ No If yes, please explain: _____

Have the tonsils and/or adenoids been removed? ◯ Yes ◯ No

Have there been injuries to their mouth or chin? ◯ Yes ◯ No

Have they been informed of any missing or extra teeth? ◯ Yes ◯ No

Have they ever had pain/tenderness in the jaw joints? (TMJ/TMD) ◯ Yes ◯ No

Do/Did they have any of the following habits?

◯ Grinding Teeth
◯ Clenching
◯ Chronic Mouth Breathing
◯ Speech Problems
◯ Tongue Thrusting
◯ Chewing/Eating Problems
◯ Finger/Thumb Sucking
Past or Present (Circle One)
◯ Prolonged Bottle/Pacifier

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim(s). I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

_____ _____

Patient Signature Date

Office: 714-842-9933 info@harnerorthodontics.com