

WILLIAM H. HARRISON, D.D.S.



SAMUEL S. BERRO, D.D.S.

PATIENT INFORMATION

DATE _____

PATIENT'S NAME _____ NICKNAME _____ PHONE _____

ADDRESS _____ CITY _____ ZIP _____

BIRTHDATE _____ SEX _____ AGE _____ SCHOOL _____ GRADE _____

PATIENT'S INTERESTS OR HOBBIES _____

SIBLINGS NAMES AND AGES _____

PATIENT'S DENTIST _____ DATE OF LAST VISIT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DO YOU KNOW ANY PATIENTS IN OUR PRACTICE? WHO? _____

PLEASE CHECK REASONS FOR SEEKING ORTHODONTIC CONSULTATION:

- SUGGESTED BY DENTIST CROWDING SPACING BAD BITE OVERBITE EXCESSIVE WEAR
- OTHER _____

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME _____ MARITAL STATUS _____ LIVING WITH PATIENT YES NO

ADDRESS _____ CITY/STATE _____ ZIP _____

YEARS AT THIS ADDRESS? _____ PHONE: HOME _____ CELL _____ WORK _____

SSN _____ BIRTHDATE _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

MOTHER'S NAME _____ MARITAL STATUS _____ LIVING WITH PATIENT YES NO

ADDRESS (if diff.) _____ CITY/STATE _____ ZIP _____

YEARS AT THIS ADDRESS? _____ PHONE: HOME _____ CELL _____ WORK _____

SSN _____ BIRTHDATE _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

DENTAL INSURANCE INFORMATION

INSURED'S NAME _____ INSURED'S SSN _____

INSURANCE CO _____ GROUP # _____ INSURANCE PHONE _____

INSURANCE CO ADDRESS _____ EMPLOYER _____

DO YOU HAVE DUAL COVERAGE? YES NO IF YES:

INSURED'S NAME _____ INSURED'S SSN _____

INSURANCE CO _____ GROUP # _____ INSURANCE PHONE _____

INSURANCE CO ADDRESS _____ EMPLOYER _____



MEDICAL HISTORY

PHYSICIAN'S NAME _____ CITY _____ LAST SEEN _____

- YES NO *Is patient experiencing any health problems? Explain* _____
- YES NO *Does patient have any history of major illness? Explain* _____
- YES NO *Is patient currently taking medications or drugs? Please list* _____
- YES NO *Is patient allergic to any medications or drugs? Please list* _____
- YES NO *Has patient's tonsils or adenoids been removed? What age* _____

HAS THE PATIENT BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> ADD, ADHD | <input type="checkbox"/> DEVELOPMENTAL DISORDER | <input type="checkbox"/> GROWTH DISORDERS | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEAD OR NECK PAIN | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PROLONGED BLEEDING |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RESPIRATORY DISORDERS |
| <input type="checkbox"/> BONE DISORDER | <input type="checkbox"/> EMOTIONAL DISORDER | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> FAINTING | <input type="checkbox"/> HIV OR AIDS | <input type="checkbox"/> TUBERCULOSIS |

OTHER CONDITIONS OR PROBLEMS NOT MENTIONED ABOVE: _____

NEAREST RELATIVE IN CASE OF EMERGENCY _____ PHONE _____

DENTAL HISTORY

- YES NO *Started teething very early or late?*
- YES NO *Primary (baby) teeth removed that were not loose?*
- YES NO *Has patient had any unpleasant experiences in a dental office?*
- YES NO *Injuries to face, mouth or teeth?*
- YES NO *Thumb or finger sucking habit? Until what age?*
- YES NO *History of speech problems?*
- YES NO *Abnormal swallowing habit (tongue thrusting)?*
- YES NO *Mouth breathing habit, difficulty breathing?*
- YES NO *Missing or extra permanent teeth?*
- YES NO *Periodontal (Gum) problems?*
- YES NO *Any teeth irritating cheek, lip or tongue?*
- YES NO *Clicking or popping of the jaw?*
- YES NO *Difficulty in opening, closing or chewing?*
- YES NO *Pain or soreness in muscles of face or around the ears?*
- YES NO *Clenching or grinding of the teeth while awake or asleep?*
- YES NO *Is patient concerned about appearance of teeth?*
- YES NO *Has patient had any previous orthodontic treatment?*
- YES NO *Has an orthodontist been consulted previously? Who? _____ Date _____*
- YES NO *Has any family member had orthodontic treatment? Who? _____*
- YES NO *Any other information that may be helpful? _____*

I understand that where appropriate, credit bureau reports may be obtained. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Parent/Guardian Signature _____ Date _____