Harvey Orthodontics

Patient Information

Patient's Name:_______________ Birth Date: ___________ Age: ______ Sex: ❑ M ❑ F
Address:_______________City:___________State:___________Zip:___________
Home Phone: ___________ Cell Phone:___________ Work Phone:___________
Are you 18 or older? If Yes, may we send appointment reminders via text to your mobile phone? ❑ Yes ❑No
email Address:___________@___________ May we send appointment reminders via email? ❑ Yes ❑ No
School: _______________ Grade: ________
Siblings: Name: ___________ Age________ Name: ___________Age:________
Siblings: Name: ___________ Age________ Name: ___________Age:________
Is there anything you would like to speak about in private? ❑ **Yes** ❑**No**
Dentist Name: _______________ Date of Last Visit: ___________
Is there anyone else in your family you would like us to see in the future? ___________ _If yes, specify age: ___________
Are there any other family members that already see us? _______________

Dental Insurance Information

Insured's Name:_______________Birth Date _____/_____/_____SSN/ID # ______ - _____ - _______
Insurance Company _______________Group No. ___________Phone ___________
Insurance Company Address: _______________
Do you have dual coverage? ❑ Yes ❑ No
2nd Insured's Name ___________ ___________Birth Date _____/_____/_____SSN/ID # ______ - _____ - _______
Insurance Company _______________Group No. ___________Phone ___________
Insurance Company Address: _______________

1st Responsible Person: _______________Birth Date: ___________ Age: ______ Sex: ❑ M ❑ F
Address:_______________City:___________State:___________Zip:___________
Home Phone: ___________ Cell Phone:___________ Work Phone:___________
May we send appointment reminders via text to your mobile phone? ❑ Yes ❑No (only one mobile number can be assigned)
email Address:___________@___________ May we send appointment reminders via email? ❑ **Yes** ❑**No**
Employer:_______________Occupation:_______________
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Relationship to Patient: ❑ Self ❑ Mother ❑ Father ❑ Other ___________
We are moving to paperless statements, by signing below you are consenting to your billing statements being sent to you by email.

Signature: _______________Date:___________

2nd Responsible Person: _______________ Birth Date: ___________ Age: ______ Sex: ❑ M ❑ F
Address:_______________City:___________State:___________Zip:___________
Home Phone: ___________ Cell Phone:___________ Work Phone:___________
May we send appointment reminders via text to your mobile phone? ❑ Yes ❑No (only one mobile number can be assigned)
email Address:___________@___________ May we send appointment reminders via email? ❑ **Yes** ❑**No**
Employer:_______________Occupation:_______________
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Relationship to Patient: ❑ Self ❑ Mother ❑ Father ❑ Other ___________
We are moving to paperless statements, by signing below you are consenting to your billing statements being sent to you by email.

Signature: _______________ Date:___________

Dental History

Have there been injuries to the face, mouth, or teeth?	❑ Yes ❑ No
Does the patient bite their nails?	❑ Yes ❑ No
Does the patient have jaw pain or tiredness?	❑ Yes ❑ No
Does the patient have pain around ear?	❑ Yes ❑ No
Does the patient suffer from dry mouth?	❑ Yes ❑ No
Does the patient grind their teeth?	❑ Yes ❑ No
Have you been informed of any missing or extra permanent teeth?	❑ Yes ❑ No
Has an orthodontist been consulted previously?	❑ Yes ❑ No
Has the patient had previous orthodontic treatment?	❑ Yes ❑ No

Medical History

Physician: ____ Date of Last Visit:________________________

Check Yes or No if the patient has a history of the following:

Aids/HIV	❑ Yes ❑ No	Cortisone Treatment	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No
Autoimmune	❑ Yes ❑ No	Drug Allergies	❑ Yes ❑ No	Nervous Disorder	❑ Yes ❑ No
Immune Problems	❑ Yes ❑ No	Endocrine Problems	❑ Yes ❑ No	Organ Transplant	❑ Yes ❑ No
Allergies	❑ Yes ❑ No	Emotional Disorders	❑ Yes ❑ No	Painful Chewing	❑ Yes ❑ No
Seasonal	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Periodontal Problems	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting, Dizziness	❑ Yes ❑ No	Pregnant	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Due Date_______________	
Asthma	❑ Yes ❑ No	Heart Condition	❑ Yes ❑ No	Prolonged Bleeding	❑ Yes ❑ No
Bone Disorders	❑ Yes ❑ No	Congenital Heart Condition	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Chest Pains	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Cerebral Palsy	❑ Yes ❑ No	Artificial Heart Valves	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Muscular Disorders	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Thyroid	❑ Yes ❑ No
Chronic Neck Pain	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	TMJ Problems	❑ Yes ❑ No
Clicking of Jaw	❑ Yes ❑ No	Type_______________		Tooth Grinding	❑ Yes ❑ No
Cold Sore	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Liver Problems	❑ Yes ❑ No		

Have tonsils and adenoids been removed? ❑ Yes ❑ No What age? ____________________________________

List any drugs or medications now being taken, give reason:

____

Are you currently taking bisphosphonates (Boniva, Fosamax)? ❑ Yes ❑ No

List any drug allergies or drug sensitivities: ____

Latex allergy? ❑ Yes ❑ No

Emergency Information

Name of nearest relative not living with you ____

Address:____City:____________________State:__________________Zip:______________

Home Phone: _____________________________________ Cell Phone:_____________________ Work Phone: ____________________

email Address:_______________________@________________________________

Primary Responsible Party Signature ____**Date** _________________