HARMONY
ORTHODONTICS

Date: _____

Child Patient Information

Patient name: _____ _____ _____ _____ _____
Last First M.I. Preferred name (Preferred Pronoun)

DOB: _____ How did you hear about our office? _____

Residence address: _____
Street City State Zip

Preferred phone number: _____ Patient's cell (if applicable): _____

Responsible Party No. 1

Responsible party: _____ _____ Marital status: ◯ Single ◯ Married ◯ Divorced
Last First

Responsible party's DOB: _____ Relationship to patient: _____

Cell phone: _____ Home phone: _____ Email: _____

Residence address: _____ ◯ Rent ◯ Own No. of years at this address? _____

Mailing address: _____ Previous address: _____
*if different than above *if less than 3 years

Employer: _____ Occupation: _____ No. years employed? _____

Responsible Party No. 2

Responsible party: _____ _____ Marital status: ◯ Single ◯ Married ◯ Divorced
Last First

Responsible party's DOB: _____ Relationship to patient:_____

Cell phone: _____ Home phone: _____ Email:_____

Residence address: _____ ◯ Rent ◯ Own No. of years at this address? _____

Mailing address: _____ Previous address: _____
*if different than above *if less than 3 years

Employer: _____ Occupation: _____ No. years employed? _____

Insurance Information

Policy holder's name: _____ DOB: _____ SSN: _____
Address (if different than above): _____
Insurance Co. name: _____ ID No. _____ Group No._____
Insurance Co. phone No. _____ Claims address: _____
Do you have dual coverage? If yes, please continue:
Policy holder's name: _____ DOB: _____ SSN: _____
Address (if different than above): _____
Insurance Co. name: _____ ID No. _____ Group No. _____
Insurance Co. phone No. _____ Claims address: _____

Emergency Contact Information

Name: _____ **Phone:** _____ **Relationship to patient:** _____

RESPONSIBLE PARTY'S SIGNATURE: **DATE**:
✖

I understand that where appropriate, credit reports may be obtained.

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Patient Medical History

Physician's name: _____ Approximate date of last physical exam: _____

Has the patient ever been under extended care of a physician? ◯ Yes ◯ No (if yes, please explain below):

_____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PAITENT HAS BEEN TREATED

◯ Anemia	◯ Excessive bleeding	◯ Pain in jaw joint(s)
◯ Asthma	◯ Heart problems	◯ Rheumatic fever
◯ Cold sores/Fever blisters	◯ Hepatitis	◯ Anxiety
◯ Diabetes	◯ HIV positive (AIDS)	◯ ADD/ADHD
◯ Depression	◯ Nervous disorders	◯ Tuberculosis
◯ Endocrine problems	◯ Autism spectrum	◯ Other: _____

Does patient need to be medicated prior to dental appointments? ◯ Yes ◯ No (if yes, please explain):

_____

Does patient gag easily? ◯ Yes ◯ No

Does patient have special needs? ◯ Yes ◯ No (if yes, please explain):

_____

Does patient have frequent ear infections? ◯ Yes ◯ No

Have tonsils and adenoids been removed? ◯ Yes ◯ No

Are any medications currently being taken? ◯ Yes ◯ No (If yes, please list and explain):

_____

Does patient have any allergies? ◯ Yes ◯ No (if yes, please list):

_____

*foods, medications, environmental (i.e… hay fever)

Patient Dental History

General Dentist (name or name of office): _____ Approximate date of last cleaning: _____

Is there any dental work to be completed? (fillings, crowns, etc.)	◯ Yes	◯ No	_____
Have there been any injuries to the face, mouth, or teeth?	◯ Yes	◯ No	_____
Has patient ever sucked their fingers or thumb?	◯ Yes	◯ No	Until what age? _____
Does patient have any speech problems?	◯ Yes	◯ No	_____
Has patient ever had orthodontic treatment?	◯ Yes	◯ No	_____
Have any family members had orthodontic treatment?	◯ Yes	◯ No	_____
Is patient a mouth breather?	◯ Yes	◯ No	
Have you been informed of extra or missing permanent teeth?	◯ Yes	◯ No	
Is there pain in the jaw?	◯ Yes	◯ No	Right, Left, or Both? _____
Is there popping or clicking in the jaw joint(s)?	◯ Yes	◯ No	Right, Left, or Both? _____
Does patient clench or grind?	◯ Yes	◯ No	
Does patient regularly have headaches?	◯ Yes	◯ No	How often? _____

What is the chief concern that brought you to our office? _____