

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Date _____
Patient's name _____
Address _____
Street
City _____ State _____ Zip _____
Birthdate _____ SS# _____
Home# _____ Cell# _____
Email address _____
School _____ Class of _____
Whom may we thank for referring you to our office?

Dental Insurance Information

Insured's name _____
Birthdate _____ SS# _____
Address, if different from patient _____
Street
City _____ State _____ Zip _____
Relationship to patient _____
Insurance co. _____
Employer _____
Do you have dual coverage? Yes No

Emergency Information

Name of nearest relative not living with you _____
Address _____
Street
City _____ State _____ Zip _____
Home# _____ Work# _____

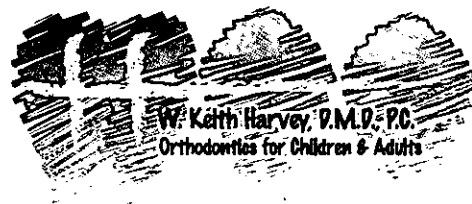
Responsible Party Information

Name _____
Residence _____
Street
City _____ State _____ Zip _____
Mailing address _____
Street
City _____ State _____ Zip _____
How long at this address? _____
Home# _____ Work# _____
Cell# _____
Email address _____
Birthdate _____ SS# _____
Relationship to patient _____
Employer _____ Years employed _____
Occupation _____
Spouse's name _____
Birthdate _____ SS# _____
Work# _____ Cell# _____
Email address _____
Relationship to patient _____
Employer _____ Years employed _____
Occupation _____

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

Signature (Parent's signature if minor) _____

Date _____



58 Mobile Street
Mobile, AL 36607
tel 251/479/9597
fax 251/479/1241

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Your Dentist

Previous/present dentist _____

Last visit date _____

Other family members seen by Dr. Harvey _____

Dental History

Why have you come to the orthodontist today? _____

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now/have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums bleed? Yes No

How many times a week do you floss? _____

How many times a week do you brush? _____

Type of bristles? Hard Med Soft

Have you inherited any family facial/dental characteristics? Yes No

If yes, explain _____

Medical History

Physician's name _____

Date of last visit _____

Your current physical health is Good Fair Poor

Please explain _____

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one _____

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week# _____

Are you nursing? Yes No Has menstruation begun? Yes No

Have you ever had any of the following diseases/medical conditions?

- | | |
|-------------------------------|------------------------------------|
| Y N Heart attack/stroke | Y N Psychiatric problems |
| Y N Cancer/chemotherapy | Y N Epilepsy/seizures/fainting |
| Y N Heart murmur | Y N Diabetes/tuberculosis (TB) |
| Y N Rheumatic fever | Y N Drug/alcohol abuse |
| Y N HIV+/AIDS | Y N Venereal disease |
| Y N Heart surgery/pacemaker | Y N Hemophilia/abnormal bleeding |
| Y N Shingles | Y N Ulcers/colitis |
| Y N Mitral valve prolapse | Y N Congenital heart defect |
| Y N Kidney problems | Y N Anemia/radiation treatment |
| Y N Artificial bones/joints | Y N Asthma/arthritis |
| Y N Artificial valves | Y N Difficulty breathing |
| Y N Sinus problems | Y N Hospitalization for any reason |
| Y N High/low blood pressure | Y N Hepatitis |
| Y N Fever blisters | Y N Blood transfusion |
| Y N Severe/frequent headaches | Y N Emphysema/glaucoma |

List any serious medical condition that you have ever had _____

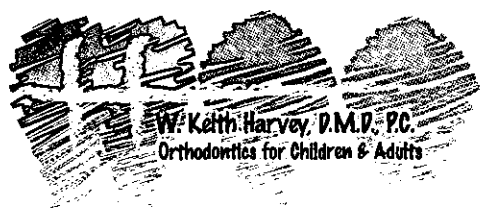
Are you allergic to any of the following?

- | | |
|------------------------|------------------|
| Y N Penicillin | Y N Erythromycin |
| Y N Dental anesthetics | Y N Codeine |
| Y N Aspirin | Y N Tetracycline |
| Y N Latex | Y N Other |

Please list any other drugs that you are allergic to _____

Do you have any of the following habits?

- | | |
|--------------------------|------------------------|
| Y N Thumb/finger sucking | Y N Lip sucking/biting |
| Y N Nail biting | Y N Other habits |



American Association of Orthodontists