DOUGLAS HARRINGTON D.D.S.
ORTHODONTICS & PEDIATRIC DENTISTRY

PATIENT INTRODUCTION

This confidential information is of great value in aiding us to better understand and treat your child

What do you want orthodontic treatment to accomplish? ____
____ Date ________________

Patient's name ____ Nickname _______________ Sex M F
(First) (MI) (Last)

Age ________ Birthdate ___/___/____ School ____________________________ Grade ________________

Address _________________________________ City _____________________ Zip ________________

Residence Phone #_________________ Cell Phone #________________ Social Security #____________________

Special interests, sports or hobbies ____

Names and ages of children in family____

Nearest relative not living with patient ____

Address ____ Phone ( ) ________________

Father's Name (or Self)______________________________________ Occupation ____________________

Address ____ City __________________ Zip ____________

Employer ____ Home Phone # _______________________

Address ____ Work Phone#________________________

Date of Birth ____________________________ Marital Status M D S W Cell Phone #_________________

E-Mail Address____Would you like to receive E-Mailed Reminders? Y N

Social Security # _______________________________________ Driver's License # ______________________

Dental Insurance Co. _____________________________________ Group # __________________________

Dental Insurance Billing Address ____

Mother's Name (or Spouse)____________________________________ Occupation ____________________

Address ____ City __________________ Zip ____________

Employer ____ Home Phone # _______________________

Employer's Address ______________________________________Work Phone #_______________________

Date of Birth ____________________________ Marital Status M D S W Cell Phone #_________________

E-Mail Address____Would you like to receive E-Mailed Reminders? Y N

Social Security # _______________________________________ Driver's License # ______________________

Dental Insurance Co. _____________________________________ Group # __________________________

Dental Insurance Billing Address ____

Dual Insurance ______Yes ______ No

Child's Primary Dental Insurance ____

Child' Secondary Dental Insurance ____

PLEASE COMPLETE REVERSE SIDE

FAMILY HISTORY

1. Physician or Pediatrician ______________________________ Phone #__________________
2. General Dentist ______________________________ Phone #__________________
3. Approximate date of last dental check-up__________________, physical examination__________________
4. Has mother or father had orthodontic treatment? YES NO
5. Whom may we thank for referring you to our office? ______________________________

MEDICAL HISTORY

1. Is the patient presently under the care of a physician? YES NO
   If so, for what reason? ______________________________
2. Is the patient currently taking any medications? YES NO
   Medicine ______________________________ Dosage __________________
3. Does your child have a heart murmur that requires premedication before dental treatment? YES NO
4. Has there been any change in the patient's health within the past year? YES NO
5. Is the patient sensitive or allergic to any drugs (e.g. penicillin)? YES NO
6. Is the patient sensitive or allergic to latex? YES NO
7. Does the patient have a history of allergies? YES NO
8. Is the patient subject to blood disorders? YES NO
9. Does the patient bruise easily? YES NO
10. Has the patient had a history of the following? If yes, please circle: **Heart Murmur or Heart Problem Rheumatic Fever Diabetes Asthma Epilepsy Tuberculosis Brain Injury Kidney Disorder Liver Disorder Lung Disorder HIV/AIDS Radiation/Chemotherapy Other:** ______________________________
11. Has your child ever been hospitalized or had surgery?
    Reason? ______________________________ Date __________________
12. Does your child have a learning disability? YES NO ______________________________

DENTAL HISTORY

1. Has there been any injuries to the face, mouth or teeth? YES NO
2. Has the patient ever sucked a thumb or finger? Until what age? __________________ YES NO
3. Does the patient have a speech problem? YES NO
4. Is the patient a mouth breather? YES NO
5. Has the patient had tongue thrust or speech therapy? YES NO
6. Have you been informed of missing or extra permanent teeth? YES NO
7. Has an orthodontist been consulted previously? Who? __________________ YES NO
8. Has the patient experienced clicking, popping or pain with the jaw? YES NO

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN FUTURE MEDICAL STATUS.

Patient, Parent or Guardian Signature ______________________________ Date __________________