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

REASON FOR VISIT _____
_____Date _____

Child's name _____ Nickname _____ Sex M F
(First) (MI) (Last)

Age _____ Birthdate ____/____/_____ School _____ Grade _____

Name & Age of Brothers _____

Name & Age of Sisters _____

Child's Address _____ City _____ Zip _____

Residence Phone ( ) _____Cell Phone#_____

Nearest Relative Not Living With Child _____

Address _____ Phone ( ) _____

Father's Name _____ Occupation _____

Father's Address _____ City _____ Zip _____

Father's Employer _____ Work Phone # _____

Employer's Address _____Home Phone#_____

Father's Date of Birth _____Marital Status: M D S W Cell Phone #_____

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

Father's Social Security # _____ Driver's License # _____

Father's Dental Insurance Co. _____ Group # _____

Dental Insurance Billing Address _____

Mother's Name _____ Occupation _____

Mother's Address _____ City _____ Zip _____

Mother's Employer _____ Work Phone # _____

Employer's Address _____Home Phone#_____

Mother's Date of Birth _____Marital Status M D S W Cell Phone #_____

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

Mother's Social Security # _____ Driver's License # _____

Mother's 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. Pediatrician _____ City _____
2. Date of last physical examination_____
3. Family Dentist_____City_____

4. Has mother or father experienced a great amount of tooth decay? YES NO
5. What is the child's favorite sport? _____ Toy? _____
6. Whom may we thank for referring you to our office? _____

MEDICAL HISTORY

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

DENTAL HISTORY

1. Is this your child's first dental visit? If no, previous dentist? _____ YES NO
2. Has your child had an unfavorable experience at another office? YES NO
3. How do you think he/she will act toward the dentist? _____
4. Does your child have a problem with his/her bite or position? YES NO
5. Has your child been seen by an orthodontist? YES NO
6. Has your child worn orthodontic appliances? YES NO
7. How many times a day does your child brush his/her teeth? _____
8. Is dental floss used? YES NO
9. Is fluoride taken in any form? (water, tablets, etc.) YES NO
10. Does your child have a history of Finger sucking _____ Lip sucking _____ Nail biting _____ Pacifier _____ ?

I HEARBY AUTHORIZE DR. DOUGLAS J. HARRINGTON TO PREFORM ANY AND ALL TREATMENT FOR THE ABOVE NAMED CHILD AND CONSENT TO SUCH METHODS, DRUGS AND AGENTS AS MAY BE INDICATED IN CONNECTION WITH HIS/HER DENTAL CARE. THIS CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE DUE ON MY ACCOUNT ONCE MY INSURANCE HAS MADE PAYMENT, OR IF NOT COVERED BY INSURANCE, FOR THE FULL AMOUNT OF INCURRED CHARGES.

Signature _____ Relation to child _____

Please note: Payment is expected at the time services are rendered, unless financial arrangements have been made prior to the appointment.