HOLLAND ORTHODONTICS

MAKING CONFIDENT SMILES IN THE 603

Thank you for your interest in our office!
Please complete both sides of this form while you wait to be seated.

Patient Name:_____
DOB: _____ Age: _____ M/F Nickname: _____
Hobbies/Interests: _____
Dentist: _____ How did you hear about us?_____
If patient is a minor: Who do they reside with? _____
School _____ Grade _____

Responsible Parties

Primary Responsible Party: Please list the person(s) responsible for this account. For divorced/separated parents, please list both parties information - our office requires consent from both parties to treat patients.

Name: _____ DOB: _____ M/F
Relationship to Patient:_____
Marital Status: _____ Spouses Name: _____
Address: _____
Street City State Zip Code
Home Phone: _____ Cell Phone: _____
Email Address: _____

IF YOU NEED SPLIT RESPONSIBLE PARTY PAYMENTS, PLEASE CHECK THIS BOX ☐

Secondary Responsible Party: (If applicable)
Name: _____ DOB: _____ M/F
Relationship to Patient:_____
Marital Status: _____ Spouses Name: _____
Address:_____
Street City State Zip Code
Home Phone: _____ Cell Phone: _____
Email Address: _____

Insurance

Name of Dental Insurance Company: _____
ID#: _____ Group # _____
Name of Insured Employee: _____ DOB: _____
Occupation: _____

Secondary Insurance: (If applicable)
Name of Dental Insurance Company: _____
ID#: _____ Group # _____
Name of Insured Employee: _____ DOB: _____
Occupation : _____

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Patient's physician _____ Phone _____
Date of last physical _____ Are immunizations up to date? Y N
Is patient presently being treated for any condition? Y N
If yes, please explain: _____

Medical Information

Has patient ever been diagnosed with any of the following conditions?

Y	N	Abnormal bleeding/bruising	Y	N	AIDS or HIV
Y	N	Allergies	Y	N	Allergies to drugs
Y	N	Allergic to latex/metals	Y	N	Asthma
Y	N	Cancer	Y	N	Chronic headaches
Y	N	Chronic adenoid/tonsil infections	Y	N	Chronic Ear Infections
Y	N	Congenital Heart Disease	Y	N	Convulsions or Seizures
Y	N	Diabetes	Y	N	Excessive gagging
Y	N	Growth & development problems	Y	N	Hearing/speech problems
Y	N	Heart murmur	Y	N	Hemophilia
Y	N	Hepatitis	Y	N	Hyperactivity / ADD / ADHD
Y	N	Kidney/liver disease	Y	N	Nutritional deficiency
Y	N	Oral ulcers	Y	N	Rheumatic fever
Y	N	Tuberculosis	Y	N	Blood transfusions
Y	N	Other_____			

Please discuss any medical problems that the patient has had _____
_____

Please list all prescriptions patient is currently taking _____
Please list all allergies patient has _____

Does the patient require antibiotic pre-medication for dental procedures? Y N
Has the patient ever been evaluated for or had orthodontic treatment? Y N
Have there been any injuries to the face, mouth, teeth or chin? Y N
Have adenoids or tonsils been removed? Y N
Has the patient been informed of any missing or extra permanent teeth? Y N
Has the patient had any pain/tenderness in their jaw joint (TMJ/TMD)? Y N
Does the patient brush their teeth daily? Y N How many times per day? _____
Does the patient floss their teeth daily? Y N

Habits

Does/did the patient have any of the following habits?

Y	N	Clenching/grinding	Y	N	Tongue Thrust
Y	N	Nail biting	Y	N	Lip sucking/biting
Y	N	Mouth breathing	Y	N	Thumb/finger sucking
Y	N	Snoring	Y	N	Dry mouth

What are your main orthodontic concerns? _____

I agree that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in patient's medical status.

Form completed by: _____ Date: _____

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