James M. Holland, D.M.D.

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
Hobbies/Interests: _____
Dentist: _____ How did you hear about us?_____

Responsible Parties

Primary Responsible Party: Please list the person(s) responsible for this account - if yourself please fill out accordingly.

Name: _____ DOB: _____ M/F
Relationship to Patient (IE: self, parent, spouse): _____
Marital Status: _____ Spouses Name: _____
Address: _____
Street City State Zip Code
Home Phone: _____ Cell Phone: _____
Email Address: _____

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: _____
Employer: _____ Occupation: _____

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

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Habits

___ Thumbsucking ___ Tooth Grinding ___ Fingersucking

___ Tongue Thrusting ___ Lip Biting ___ Nail Biting

___ Speech Irregularities ___ Mouth Breathing ___ Other _____

Health History

Please list all (if any) allergies: _____
Please list all (if any) medications taken: _____
Is a physician presently treating patient? If so, please explain: _____
_____
Have tonsils or Adenoids been removed? _____
Any difficulty breathing through the nose? _____
Problems swallowing or chewing food? _____
Any pain when opening or closing mouth? _____
Jaw clicking or locking? _____

Please check all that apply:

___ Rheumatic Fever	___ Chickenpox	___ Repeated Headaches	___ Asthma
___ Blood Disease	___ Convulsions	___ Measles	___ Food Allergies
___ Repeated Sore Throats	___ Diabetes	___ Mumps	___ Polio
___ Repeated Colds	___ Drug Allergies	___ Tuberculosis	___ Pneumonia
___ Hemophilia	___ Anemia	___ Hay Fever	___ Hepatitis

Any major falls, accidents, or operations? _____
Any other medical information we should know about? _____
_____

What in particular brings you in for an orthodontic evaluation? (Any main concerns?)
_____
Would you like to have braces if recommended? _____

Questionnaire completed by: _____ Date: _____