SOUTHERN ORTHODONTIC SPECIALISTS, P.C.

HUNTER B. HARRISON, D.D.S., M.S.

sosbraces.com

Date _____ 20____ S.S.# _____

Patient _____ Age _____ Sex: Male ◯ Female ◯

Date of Birth _____ Home Phone _____ Cell Phone _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Spouse _____ Phones (H) _____ (C) _____ S.S.# _____

Spouse's Employer _____ Occupation _____ Work Phone _____

Spouse's Work Address _____ City _____ State _____ Zip _____

Person Responsible for Account _____ Phones (H) _____ (C) _____ S.S.# _____
(if different from patient)

Street _____ City _____ State _____ Zip _____

Closest Relative _____ Phones (H) _____ (C) _____

Street _____ City _____ State _____ Zip _____

Orthodontic Insurance Yes ◯ No ◯ What Company? _____

Your Regular Dentist _____ Date of last check-up _____

Whom may we thank for referring you to our office? _____

What do you think is your orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

Are you in good health? Yes ◯ No ◯ Explain: _____

Any major or unusual illnesses? Yes ◯ No ◯ Explain: _____

Currently being treated by physician? Yes ◯ No ◯ Reason: _____

Currently taking medication? Yes ◯ No ◯ Names & Reasons: _____

Allergies Yes ◯ No ◯ List: _____

Drug Sensitivity Yes ◯ No ◯ List: _____

Please check if you have or have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
◯	◯	Anemia	◯	◯	Hepatitis	◯	◯	Endocrine Problems	◯	◯	Is the patient in a risk group for AIDS?
◯	◯	Blood Disease	◯	◯	Bone Disorders	◯	◯	Glaucoma	◯	◯	Tonsils Removed: Age:
◯	◯	Prolonged Bleeding	◯	◯	Epilepsy	◯	◯	Heart Problems	◯	◯	Adenoids Removed: Age:
◯	◯	Jaundice	◯	◯	Herpes	◯	◯	Tuberculosis	◯	◯	Asthma
◯	◯	Rheumatic Fever	◯	◯	Frequent Colds or Flu	◯	◯	Diabetes	◯	◯	Mouthbreathing: While awake? ◯
◯	◯	Scarlet Fever	◯	◯	Tonsillitis	◯	◯	Adenitis			While asleep? ◯

Names and ages of children: _____ Have any had orthodontic treatment? Yes ◯ No ◯

Yes	No				
◯	◯	Have you had any severe head or face injuries? Explain:			By whom? _____
◯	◯	Have you had a history of thumb sucking or finger sucking? Stopped?	Yes ◯	No ◯	When? _____
◯	◯	Do you play any musical (wind) instruments? What?			
◯	◯	Have you consulted or been treated by an orthodontist previously?	Yes ◯	No ◯	By whom? _____

Do you have a history of:

◯ Clenching teeth
◯ Jaw joint soreness
◯ Grinding teeth
◯ Jaw joint clicking
◯ Headaches (more than normal)
◯ Jaw joint popping
◯ Muscular soreness around the head and neck
◯ Ringing in the ears

Any other helpful information: _____

Med. History Updates _____

Signature of patient: _____

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