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 _____ School Attending _____

Home Address _____ City _____ State _____ Zip _____

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

Father's Address _____ City _____ State _____ Zip _____

Father's Employer _____ Occupation _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

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

Mother's Address _____ City _____ State _____ Zip _____

Mother's Employer _____ Occupation _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

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

Guardian's Address _____ City _____ State _____ Zip _____

Closest Relative (other than parent or guardian) _____ Phone (H) _____ (C) _____

Street _____ City _____ State _____ Zip _____

Person Responsible for Account _____ Phones (H) _____ (C) _____ S.S.# _____

Street _____ City _____ State _____ Zip _____

Orthodontic Insurance Yes ◯ No ◯ What Company? _____

Patient's Regular Dentist _____ Date of last check-up _____

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

What do you think is the patient's orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

Is the patient 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 patient has or 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 brothers and sisters: _____ Have any had orthodontic treatment? Yes ◯ No ◯

By whom? _____

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

Does the patient have a history of:

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

Any other helpful information: _____ Med. History Updates _____

Signature of patient (or parent of a minor): _____

7732 Airways Boulevard | Southaven, Mississippi 38671 | 662-349-0777
256 Poplar View Parkway | Collierville, Tennessee 38017 | 901-853-9934