Welcome to Our Office

545 - 4th Avenue South
St. Petersburg, Florida 33701
(727) 822-3156

168 - 14th Street S.W., Suite A
Largo, Florida 33770
(727) 822-3156

JOHN B. HARRISON, D.D.S., M.Sc.
Orthodontist

Name________________________ Sex ☐ M ☐ F Date _____/_____/_____Age _____

Birthdate _____/_____/_____ Marital Status ☐ S ☐ M ☐ W ☐ D Nickname ____________

Address________________________ City____________________ Zip __________

Phone ______________ / ______________ / ______________
Home Cell Business

Email Address ________________________________

Employed By ____________________ Occupation____________________

School ________________________ Grade ______________

Hobbies / Sports ________________________________

Brother/Sister (Names & Ages)________________________

Has anyone else in the family been treated in this office?____________________

Has patient had previous orthodontic consultation or treatment? ______________

Whom may we thank for referring you?________________________

What is it about your teeth/bite and/or appearance that has brought you to see us today?______________

____

PARENT /SPOUSE INFORMATION

Father/Husband

Name________________________

Address ________________________

Employed By________________________

Occupation ________________________

Phone ______________ / ______________
Home Business/Cell

Mother/Wife

Name ________________________

Address ________________________

Employed By ________________________

Occupation ________________________

Phone______________ / ______________
Home Business/Cell

Person responsible for account ________________________________
Name/billing address if different

Do you have orthodontic insurance coverage? ☐ Yes ☐ No

Do you have a Flex Plan? ☐ Yes ☐ No

Filing Date ____________________

Insurance Company ______________ ID Number ______________ Phone ______________

Employer ____________________ Employer Address ____________________

Employer Phone____________________ Policy Holder's Birthday ____________________

(continued on reverse side)

DENTAL

How does the patient feel about wearing "braces"?____________________

Does anyone else in family have a similar orthodontic problem? ☐ Yes ☐ No

Patient's Dentist____________________

Does patient receive regular dental checkups? ☐ Yes ☐ No Last dental exam____________________

Is patient satisfied with past dentistry? ☐ Yes ☐ No Any unfavorable dental experiences?____________________

____

Does the patient have a history of any of the following?

Thumb/finger sucking	Food traps	Head/neck/dental injury
Nail biting	Cold Sores/Abscesses	Speech problems
Gum disease/bleeding gums	Mouth breathing	Tongue Thrust
Missing teeth/extra teeth	Noise/discomfort with jaw joint	Snoring
Sensitive teeth (hot/cold)	Clenching/grinding of teeth	Difficulty sleeping
		Poor dietary habits

MEDICAL

Patient's Physician____________________ Phone____________________

Last exam____________________ Patient's overall health status? ☐ Excellent ☐ Good ☐ Poor

Is the patient allergic to anything (Drugs, Food s , Pollen, Latex, Metals, Plastics)?____________________

Is patient presently under medical care? ☐ Yes ☐ No ____________________

____

Drugs or medications now being taken and reason? ____________________

____

For your protection as well as the protection of others.

Has the patient had any of the following? (Please Circle)

Adenoids removed	Epilepsy/seizures	Major surgery
AIDS/HIV positive	Handicaps/Disabilities	Medical emergency
Alcohol/drug addiction	Hearing Impairment	Nasal airway problems
Arthritis	Heart problems	Rheumatic fever
Asthma	Hepatitis	Sexually transmissible disease
Accident/injury	High blood pressure	Tobacco usage
Bleeding disorders	Immune disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	

Is there any other information you think we should know about to improve your experience with our office?

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____________________ PATIENT OR PARENT'S SIGNATURE

____________________ DATE