BRYAN J. HOLLIS, D.D.S., PC

ORTHODONTICS

Date_____ Regular Family Dentist_____

Whom may we thank for telling you about our office? _____

PATIENT INFORMATION

Name (last)_____(first)_____(MI)____Nickname_____

Age: _____ Birth date ___/___/___ Sex _____ Height_____ Email_____

Address _____City _____St_____ Zip_____

Home Ph:_____ Cell Ph:_____ Social Security # _____

**Please CIRCLE the best phone number for appointment reminders

**Would you like to receive text message appointment reminders? Yes No **Email reminders? Yes No

Who should we contact in a case of emergency? NAME_____PHONE_____

RELATION_____PHYSICIAN: _____PHONE_____

WHO WILL BE FINANCIALLY RESPONSIBLE FOR TREATMENT? _____

IF PATIENT IS A CHILD: SCHOOL_____ GRADE _____

ANY SIBLINGS (Names & Ages)_____

ANY SIBLINGS BEING TREATED HERE ALREADY (Names) _____

IF PATIENT IS AN ADULT: Occupation: _____ Work Ph: _____

Employer: _____ How Long: _____

FAMILY INFORMATION

FATHER (OR HUSBAND'S) _____ OCCUPATION_____

ADDRESS (if different from patient) _____ PHONE (if different)_____

EMPLOYER_____ How Long_____ BUSINESS PH: _____

SOCIAL SECURITY# _____ HEIGHT (natural father)_____

MOTHER (OR WIFE'S) _____ OCCUPATION _____

ADDRESS (if different from patient) _____ PHONE (if different)_____

EMPLOYER _____How Long_____ BUSINESS PH: _____

SOCIAL SECURITY# _____ HEIGHT (natural mother) _____

ORTHODONTIC/DENTAL INSURANCE INFORMATION

INSURED'S NAME_____DOB____/____/____ INSURED SSN #_____

INSURANCE CO. _____ POLICY#/GROUP#_____

INSURANCE ADDRESS_____ PHONE # _____

DO YOU HAVE DUAL COVERAGE (TWO INSURANCES) YES NO IF YES:

INSURED'S NAME: _____DOB____/____/____ INSURED'S SSN **#** _____

INSURANCE CO. _____ POLICY # /GROUP#_____

INSURANCE CO. ADDRESS_____ PHONE #_____

MEDICAL HISTORY

PLEASE CIRCLE THOSE THAT APPLY:

Anemia	Hepatitis	Kidney problems	AIDS
Rheumatic Fever	Heart disease	Heart Murmur	Stroke
Tuberculosis	Diabetes	Endocrine problems	Bone Disorders
Epilepsy	Psychiatric care	Cleft lip/palate	Allergies
Tonsils removed	Adenoids removed	Emotional disturbances	Asthma
Speech/Hearing problem	Tonsillitis/Adenitis	High/Low blood pressure	Drug Sensitivity
Neurological problems	Radiation Treatment	Venereal disease	Pregnancy
Ulcer or Colitis	Prolonged bleeding	Speech therapy	Dizziness

OTHERS DESCRIBE: _____

_____

YES NO Has the patient been under the care of a physician during the past two years, other than for routine examination?

Why _____

Physician's Name _____Phone # _____

YES NO Has the patient ever been treated in an emergency room?

Why _____

YES NO Has the patient ever had any allergic or unfavorable reactions to any medicine or food?

Describe _____

YES NO Does the patient presently take any daily medication either prescribed by a doctor or over the counter?

What _____

YES NO **GIRLS ONLY:** Has the patient started her menstrual cycle? If yes, at what age? _____

YES NO **BOYS ONLY:** Has the patient's voice changed? If yes, at what age? _____

DENTAL HISTORY

PLEASE CIRCLE THOSE THAT APPLY

Head/face injuries	Dental injuries	Thumb/finger sucking
Difficult oral surgery	Clench/grind teeth	Jaw or pain around ear
Frequent headaches	Bleeding gums	Sensitive teeth
Frequent cold sores	Periodontal treatment	Cigar/Pipe Smoking
Mouth Breathing	Cheek/lip/nail biting	Click/Pop of jaw joint

COMMENTS: _____

How often do you visit your regular dentist? _____(Times per year) Date of last visit _____

What was done at your last visit? _____

What is scheduled for your next visit? _____

What do you feel is the primary concern about the patient's/your teeth? _____

YES NO Has the patient ever had previous orthodontic consultation and/or treatment?

YES NO Has any member of the family had orthodontic treatment?

YES NO Are you aware that some appointments will infringe on school and or work?

YES NO Does the patient play a musical instrument with his/her mouth?

YES NO If the patient is a child, is the child concerned about the appearance of his/her teeth?

Signature (parent or guardian if minor) _____**Date**_____