Dr. James M. Holland

Orthodontics

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 Nickname: _____________________
Siblings Names/Ages: ____
Hobbies/Interests: ____
Dentist: ____________________ How did you hear about us?____________________

Responsible Parties

Primary Responsible Party: Please list the person(s) responsible for this account. For divorced/separated parents, please list both parties information - our office requires consent from both parties to treat patients.

Name: ____________________________________ DOB: __________________ M/F
Relationship to Patient:____
Marital Status: ____________________ Spouses Name: ________________________
Address: ____
Street City State Zip Code
Home Phone: _______________________ Cell Phone: __________________________
Email Address: ____

IF YOU NEED SPLIT RESPONSIBLE PARTY PAYMENTS, PLEASE CHECK THIS BOX ☐

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: ______________
Occupation: _____________________________

Secondary Insurance: (If applicable)
Name of Dental Insurance Company: ____
ID#: _____________________________________ Group # _____________________
Name of Insured Employee: ___________________________ DOB: ______________
Occupation : ___________________________________

Continued on Back:

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Habits

___ Thumb Sucking ___ Tooth Grinding ___ Finger Sucking

___ Tongue Thrusting ___ Lip Biting ___ Nail Biting

___ Speech Irregularities ___ Mouth Breathing ___ Snoring

___ Dry Mouth ___ 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 your child to have braces if recommended? ______________________________

Questionnaire completed by: ______________________________ Date: ______________