Orthodontics for Adults & Children
Invisible Braces for Adults & Teens
Dr. Garret F. Harnett DDS MS PC
18555 N. 79th Avenue, Suite A102 • Glendale, AZ 85308
Phone 623-487-5800

PATIENT INFORMATION

Date _____

Patient's Name _____
Last First Middle

Address _____
Street Apt. # City Zip

Home Phone _____ Birthdate _____ Social Security Number _____

If patient is a minor, give parent's or guardian's name _____

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

Patient's Dentist _____ Date of Last Dental Check-up _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Address _____
Street Apt. # City Zip

How long at this address? _____ Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Social Security Number _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security Number _____ Birthdate _____ Work Phone _____

Cell Phone _____ Email Address _____

DENTAL INSURANCE INFORMATION

Primary Coverage

Insured's Name _____ Insured's Social Security Number _____

Relationship to Patient _____

Insurance Company _____ Group No. _____ Policy No. _____

Insurance Company Address _____ Phone Number _____

Secondary Coverage

Insured's Name _____ Insured's Social Security Number _____

Relationship to Patient _____

Insurance Company _____ Group No. _____ Policy No. _____

Insurance Company Address _____ Phone Number _____

MEDICAL HISTORY

Name of Physician _____

Phone _____ Date of Last Exam _____

Address _____

Do you have a current medical problem? ❑ Yes ❑ No If so, what? _____

Have you ever had any of the following?

Heart Attack	❑ Yes ❑ No	Psychiatric / Learning Problems	❑ Yes ❑ No
High / Low Blood Pressure	❑ Yes ❑ No	Epilepsy / Seizure / Fainting Spells	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Heart Murmur / Heart Disease	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	HIV+ / Aids	❑ Yes ❑ No
Hemophilia / Abnormal Bleeding	❑ Yes ❑ No	Heart Surgery / Pacemaker	❑ Yes ❑ No
Cancer / Chemotherapy / Radiation	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No
Kidney Problems	❑ Yes ❑ No	Artificial Bones / Joints	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Sinus / Breathing Problems	❑ Yes ❑ No
Adenoids / Tonsils Removed	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Congenital Heart Disease	❑ Yes ❑ No
VD (Syphilis, gonorrhea)	❑ Yes ❑ No	ADHD	❑ Yes ❑ No
Major Operations	❑ Yes ❑ No	Pain / Pressure / Tightness in Chest	❑ Yes ❑ No
Autism	❑ Yes ❑ No		

List any other medical conditions: _____

_____

_____

Please check all that apply:

Pregnant	❑ Yes ❑ No	Premature Birth	❑ Yes ❑ No
On a Prescribed Diet	❑ Yes ❑ No	Using Dilantin or Equivalent	❑ Yes ❑ No
Using Thyroid Drugs	❑ Yes ❑ No	Using Hormones (incl. birth control)	❑ Yes ❑ No
Using Anxiety Medications	❑ Yes ❑ No	Genetic Disorders	❑ Yes ❑ No

Have you ever taken Bisphosphonate drugs? ❑ Yes ❑ No

Are you taking any medications? If yes, please explain _____

_____

_____

Have you ever experienced an allergic reaction to:

Aspirin / Codeine	❑ Yes ❑ No
Sulfa Drugs	❑ Yes ❑ No
Dental Anesthetics	❑ Yes ❑ No
Penicillin / Tetracycline / Erythoromycin	❑ Yes ❑ No
Latex / Rubber Gloves	❑ Yes ❑ No

Other: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

PATIENT DENTAL HISTORY

What is the main reason for seeking orthodontic treatment? _____

Have you had previous orthodontic treatment? If so, by whom? _____ ❑ Yes ❑ No

Do you have missing permanent teeth? If so, list: _____ ❑ Yes ❑ No

Do you premedicate before your dental appointment? ❑ Yes ❑ No

Do you have difficulty swallowing? ❑ Yes ❑ No

Do your gums bleed when they are brushed? ❑ Yes ❑ No

Have you ever been told you have “gum disease” or periodontitis? ❑ Yes ❑ No

Is any part of your mouth sensitive to temperature or pressure? ❑ Yes ❑ No

Does food catch between your teeth? ❑ Yes ❑ No

Do you have any soreness around your eyes or ears? ❑ Yes ❑ No

Do you have any unpleasant odor or taste in your mouth? ❑ Yes ❑ No

Are you currently experiencing any pain? ❑ Yes ❑ No

Have other family members had treatment in our office? If so, list: _____ ❑ Yes ❑ No

Do you have any of the following:

Ringing in the Ears	❑ Yes ❑ No	Pain in Teeth	❑ Yes ❑ No
Neck Pain	❑ Yes ❑ No	Face Pain	❑ Yes ❑ No
Back Pain	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No
Headaches	❑ Yes ❑ No	Grinding of Teeth	❑ Yes ❑ No
Dizziness	❑ Yes ❑ No	Popping / Clicking of Jaw Joint	❑ Yes ❑ No

Have you ever been in an accident? ❑ Yes ❑ No

Explain _____

Have you ever experienced a blow to the jaw? ❑ Yes ❑ No

Explain _____

Have you ever had an injury to your mouth / teeth / chin? ❑ Yes ❑ No

Explain _____

Has your jaw joint ever locked or felt like it was sticking? ❑ Yes ❑ No

Explain _____

Would you say your dental health is: ❑ Good ❑ Fair ❑ Poor

By signing below, I certify that the information I have provided today is complete and accurate. I also understand that it is my responsibility to inform the office of any changes regarding my (or my child’s) medical health. I authorize the dental staff to perform necessary dental services that I or my child may need during diagnosis and treatment.

I authorized payment of dental benefits otherwise payable to me, directly to this office.

Signature _____ Date _____