5 Commons Blvd.
Seneca, SC 29678
864.885.1579
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HOLLIDAY orthodontics
...because Your Smile Says it All!

11 Business Center Dr. #105
Eastanollee, GA 30538
706.827.0088
info@ hollidayorthodonticspc.com

PATIENT INFORMATION:

Date:_____

Name:_____ Preferred Name:_____
Birthday:_____ Age:_____ SS# _____ ☐ Male ☐ Female
Street Address: _____
City/State/Zip Code: _____
Home Phone:_____ Cell Phone:_____
Email Address:_____
Marital Status _____ Spouse's Name:_____
To Whom Should Correspondence Be Sent (circle)?
Mr. Mrs. Ms. Dr. Mr.&Mrs. Dr.&Mrs. Dr.&Mr. Rev.&Mrs. Other: _____
How would you prefer to receive appointment reminders from our office (circle)? Phone Text Email
If you prefer Phone Calls or Text Reminders: Please provide the best number to use:_____

WORK INFORMATION

Occupation: _____
Employer:_____ Work Phone:_____

DENTAL INSURANCE INFORMATION:

Insured's Name:_____ DOB:_____
Insurance Company/Address: _____
Insured SS # /Policy Number:_____
Does your Insurance Cover Adult Orthodontics? ☐Yes ☐No ☐ Unsure
Do you have Secondary Dental Insurance? ☐ Yes ☐ No

MEDICAL HISTORY

Physician: _____
Are you taking any medications? _____
Are you allergic to any of the following?
☐ Medications _____ ☐ Latex ☐ Metals (Nickel) ☐ Other_____
Do you require antibiotics for dental cleanings (prophylaxis)? ☐ Yes ☐ No

Please check the box if you have ever had or been diagnosed with any of the following:

☐ Heart Murmur	☐ Congenital Heart Defect	☐ Rheumatic Fever	☐ Heart Attack
☐ Heart Surgery/Pacemaker	☐Artificial Valves	☐ High/Low Blood Pressure	☐ Scarlet Fever
☐ Cancer	☐ Diabetes	☐ Convulsions/Epilepsy	☐ HIV/AIDS
☐ Hepatitis	☐ Tuberculosis	☐ Emphysema/Difficulty Breathing	☐ Asthma
☐ Sinus Problems	☐ Hemophilia	☐ Blood Transfusions	☐ Anemia
☐ Abnormal Bleeding	☐ Kidney/Liver Problems	☐ Shingles	☐ Fever Blisters
☐ Severe Headaches/Migraines	☐ Hearing Impairment	☐ Joint Replacements	☐ Glaucoma
☐ Venereal Disease	☐Drug/Alcohol Abuse	☐ Dental Anxiety	☐ ADD/ADHD

☐ Handicaps/Disabilities_____
☐ Any Operations/Hospital Stays _____

☐ Any Other Medical Issues Our Staff should know about that are not listed above? _____
_____

DENTAL HISTORY

Dentist: _____ Last Dental Cleaning:_____
Why have you come to the orthodontist today?_____
How would you rate your current dental health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent
How many times a day do you brush? _____ Floss?_____
Do your gums bleed when you brush/floss? ☐ Yes ☐ No

Do you have any of the following habits?
☐ Grinding/Clenching Teeth ☐Thumb/Finger Sucking ☐ Nail Biting ☐Cheek/Lip Biting
☐Chewing on Objects (Pens/Pencils) ☐Mouth Breathing ☐ Snoring ☐ Ice Crunching
☐ Other _____

Have you ever had any pain or tenderness in your jaw joints or been told you have TMJ/TMD? ☐ Yes ☐ No
Have you ever had an injury to your teeth or jaws? _____
Do you get frequent headaches? ☐ Yes ☐ No

Are you unhappy with the position of your teeth? ☐ Yes ☐ No
Are you unhappy with your facial appearance in anyway? ☐ Yes ☐ No
Are you unhappy with your profile or the position of your chin? ☐ Yes ☐ No

Are you interested in information about any other services our office provides?
☐ Botox/Xeomin ☐ Dermal Fillers ☐ Nightguards/Splints ☐ Home Bleaching ☐ Mouthguards

REFERRAL INFORMATION

How did you hear about our office?
☐ Our Dentist ☐ Staff Member at the Dentist ☐ Previous Holliday Orthodontic Patient
☐ Internet Search ☐ Our Website ☐ Social Media (Facebook/Instagram)
☐ Other

Is there someone specific we should thank for referring you to our office? _____

Please list any concerns or questions you would like for Dr. Holliday to address at this appointment:
_____
_____
_____
_____

Signature _____ Date _____
Relationship to Patient: _____

Please notify our office of any changes in Medical History and/or Medications