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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:_____ Birthday:_____ Age:_____
Preferred Name:_____ ☐ Male ☐ Female
Street Address: _____
City/State/Zip Code: _____
Home Phone:_____ Cell Phone:_____
Email Address:_____
School:_____ Grade:_____
Hobbies/Sports/Special Interests:_____
Siblings/Ages:_____

PARENT/GUARDIAN INFORMATION:

(Parents Marital Status:_____)
(Please write same, if indicated)

MOTHER/GUARDIAN:

Name: _____ SS #_____ Birthday:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Employer:_____ Work Phone:_____
Occupation: _____

FATHER/GUARDIAN:

Name: _____ SS #_____ Birthday:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Employer:_____ Work Phone:_____
Occupation: _____

To Whom Should Correspondence Be Sent (circle)?
Mr. Mrs. Ms. 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 would like a Phone Call or Text, Please provide us with the number to use:_____

DENTAL INSURANCE INFORMATION:

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

MEDICAL HISTORY

Physician: _____

Is your child taking any medications? _____

Is your child allergic to any of the following?

☐ Medications _____ ☐ Latex ☐ Metals (Nickel) ☐ Other_____

Does your child require antibiotics for dental cleanings (prophylaxis)? ☐ Yes ☐ No

Please check the box if your child has ever had or been diagnosed with any of the following:

☐ Heart Murmur	☐ Congenital Heart Defect	☐ Diabetes	☐ Abnormal Bleeding
☐ Cancer	☐ Convulsions/Epilepsy	☐ Rheumatic Fever	☐ Hearing Impairment
☐ HIV/AIDS	☐ Hemophilia	☐ Asthma	☐ Hepatitis
☐ Tuberculosis	☐ Kidney/Liver Problems	☐ Handicaps/Disabilities	☐ Scarlet Fever
☐ ADD/ADHD	☐ Dental Anxiety	☐ Autism/Aspergers	

☐ 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 did you bring this child to the orthodontist today?_____

Is the child's water fluoridated or taking fluoride supplements? ☐ Yes ☐ No

Has the child ever had any pain or tenderness in the jaw joints (TMJ/TMD)? ☐ Yes ☐ No

Has the child ever had an injury to the teeth or jaws?_____

How many times a day does the child brush?_____ Floss?_____

Does the child currently have or have had 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 _____

Has your child ever had any pain or tenderness in their jaw joints or been told they have TMJ/TMD?

☐ Yes _____

Has your child ever had an injury to their teeth or jaws? ☐ Yes _____

Does your child get frequent headaches? ☐ Yes _____

Are you (or your child) unhappy with the position of their teeth? ☐ Yes ☐ No

Are you (or your child) unhappy with their facial appearance in anyway? ☐ Yes ☐ No

Are you (or your child) unhappy with their profile or the position of their chin? ☐ Yes ☐ No

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