Harry L. Dougherty Jr., D.D.S., M.S.

Orthodontics Exclusively

Account #_____

ADULT

ORTHODONTIC CONSULTATION

TODAY'S DATE_____

Patient's Name_____ Name you like to be called_____
Age____Birthdate____/____/_____Hm Phone_____Work#_____ Cell _____
Address_____City_____State_____Zip _____
Email _____
Do you play a musical instrument?_____ Whom may we thank for referring you to our office?_____

Employer_____**Occupation**_____**No. of yrs. Employed**____
Social Security # _____-_____-_____

RESPONSIBLE PARTY: ❑ **Same as above**
Name_____
Last First Middle Marital status
Residence_____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address?_____Previous Address (if less than 3 yrs) _____
Street City State Zip
Spouse's Name _____
Last First Middle
Employer _____Occupation _____ No. of years employed _____
Social Security #_____-_____-_____Birthdate_____/____/_____Work Phone _____

INSURANCE INFORMATION
Insured's Name_____Insured's S.S. #_____-_____-_____ Ins. Co._____
Insurance Co. Address_____Group No._____ Phone #_____
Insured's Employer_____ Insured's Birthdate_____/____/_____
Do you have dual coverage? Yes ❑ No ❑ If yes:
Insured's Name_____Insured's S.S. #_____-_____-_____Ins. Co._____Group No._____
Insurance Co. Address_____ Phone #_____Insured's Employer _____

MEDICAL HISTORY
Physician Name_____**Please explain the following:**

Yes No Are you currently under any medical treatment? _____
Yes No Do you have pain, clicking, and/or popping noises in jaw joint?_____
Yes No Are you aware of either clenching or grinding of teeth? _____
Yes No Do you have frequent headaches? How often? _____
Yes No Do you have ear problems? (aches, ringing, dizziness, fullness) _____
Yes No Do you have difficulty breathing through the nose? _____
Yes No Do you have habits such as nailbiting, finger or thumb sucking, lip or cheek biting? _____
Yes No Do you have speech problems, or are you in speech therapy? _____
Yes No Have you had your tonsils and/or adenoids removed? _____
Yes No Has there been any history of (please circle): Joint swelling, Asthma, TB, Aids, Kidney or Liver condition, Epilepsy, Rheumatic fever or other major illness?Explain: _____
Yes No Do you bleed easily? _____
Yes No Is there a tendency to faint or become dizzy? _____
Yes No Do you have any allergies?(sulphur, penicillin, novocaine, etc.) _____
Yes No Are you currently taking any medication? List: _____
Yes No Do you have a heart murmur?_____Do you pre-medicate? _____Cardiologist_____
Yes No Do you smoke or chew tobacco? _____

DENTAL HISTORY
Name of Dentist_____**Date of last visit** _____

Yes No Have there been any injuries to the teeth? _____
Yes No Were any teeth removed by extractions? _____
Yes No Have we treated any other family members?_____Who: _____
What would you like to have orthodontic treatment accomplish? _____

How did you hear about us? Patient Referral ❑ Staff Referral ❑ Dental Referral Other ❑

*I understand where appropriate a credit report may be obtained.

Signature_____Date_____

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