PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Birthdate_____ Gender M F
Circle One

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

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

Person to Contact in case of Emergency/Phone #_____

RESPONSIBLE PARTY 'A' INFORMATION

Name_____ Relationship to Patient_____

Address _____
Street City Zip

Home Phone_____ Cell Phone _____Work Phone_____

Email address_____

Birthdate_____Employer_____

RESPONSIBLE PARTY 'B' INFORMATION

Name_____ Relationship to Patient_____

Address _____
Street City Zip

Home Phone_____ Cell Phone _____Work Phone_____

Email address_____

Birthdate_____Employer_____

DENTAL INSURANCE INFORMATION

Subscribers's Name_____ Social Security #._____

Insurance Company _____ Group #._____ Sub. ID #. _____

Insurance Co. Address_____ Phone #._____

Do you have a secondary insurance? Yes_____ No_____ If yes:

Subscribers Name_____ Social Security #. _____

Insurance Company_____ Group #._____ Sub. ID #._____

Insurance Co. Address_____ Phone #._____

(Medical History on reverse side of form)

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Please circle Yes or No (If Yes, please fill in details):

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Are you pregnant? _____
Yes No Are you currently taking any Bisphosphonates (actonel, fosamax, boniva)? _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

Current Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Please circle Yes or No (If Yes, please fill in details):

Yes No Are you presently in any dental pain? _____
Yes No Have you ever chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Do your teeth or jaws ever feel sore when you wake in the morning? _____
Yes No Does your jaws click or pop? _____
Yes No Do you clench your teeth during the day? _____
Yes No Do you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Any allergies we need to be aware of (latex, metals, lidocaine)? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. In addition, I authorize Dr. Gold to perform a complete orthodontic evaluation.

Signature: _____ Date: _____