

PATIENT INFORMATION

Patient # _____

Name _____
Last First M

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Birthdate _____

ABOUT OUR NEW PATIENT

I prefer to be called _____ Sex: Male Female

Hobbies/Sports: _____

How did you choose our office? (Check one or more)

- Know the orthodontist Referred by one of our staff
 Referred by family dentist Family/friend
 Location Phone book

May we thank anyone besides your dentist for referring you?

If yes, please list: _____

DENTAL HISTORY

Check any of the following which you had or have at present:

- Bad experience in a dental office Injuries to face, mouth, or teeth
 Nervous about orthodontic treatment Jaw pain, locking, clicking or popping
 Recurring mouth sores Severe or frequent headaches
 Gum disease Grinding or clenching teeth
 Missing or extra teeth Leaning on chin or face
 Mouth breather Lip, cheek, or nail biting
 Speech problems Frequent gum chewing
 Tonsil or adenoid problem Tooth extractions
 Tongue or finger habit (stopped at age _____) Braces, retainers, space maintainers
Prior orthodontic evaluation

Date of last dental exam ___/___/___ last cleaning ___/___/___

Patient's Dentist _____

Have we treated any other members of your family? Yes No

If yes please list: _____

Are there any others in your family with similar orthodontic problems? Yes No

What are the main concerns that you would like orthodontics to Accomplish?

MEDICAL HISTORY

Please describe your general health: good fair poor

Have you been under the care of a medical doctor during the past two years? Yes No

Explain: _____

Have you taken any drugs or prescription medications the past two years? Yes No

Please list: _____

Are you allergic to any dugs or medications? Yes No

Please list: _____

WOMEN: Is there any possibility you are pregnant? Yes No

Check any of the following which you have had or have at present:

- | | |
|---|---|
| Allergies/hives/
<input type="checkbox"/> hay fever | Joint Problems
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial joints
<input type="checkbox"/> Rheumatism |
| Blood Disorders
<input type="checkbox"/> Abnormal bleeding
<input type="checkbox"/> Anemia
<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Diabetes/high blood sugar | <input type="checkbox"/> Kidney trouble
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Yellow jaundice |
| <input type="checkbox"/> Cancer/Chemotherapy/Radiation
<input type="checkbox"/> Cortisone medication
<input type="checkbox"/> Drug addiction
<input type="checkbox"/> Ear trouble | Lung Disease
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Tuberculosis (TB) |
| Eye disorders
<input type="checkbox"/> Glaucoma | <input type="checkbox"/> Muscle disorders
<input type="checkbox"/> Nerve disorders |
| Heart problems
<input type="checkbox"/> Angina
<input type="checkbox"/> Artificial heart valve
<input type="checkbox"/> Congenital heart lesions
<input type="checkbox"/> Heart surgery
<input type="checkbox"/> Murmurs
<input type="checkbox"/> Pacemakers
<input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Fainting or dizzy spells
<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Psychiatric treatment
<input type="checkbox"/> Stroke
<input type="checkbox"/> Sinus troubles
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> AIDS/HIV+ |

Do you have any disease, condition, or problem not listed?

If yes please list: _____

Physicians name: _____

In the event of an emergency, whom may we call:

Name: _____ Relation: _____

Home: _____ Work: _____ Ext: _____

I understand it is my responsibility to inform this offer of any changes in medical status: _____ (your initials) _____ (DR)

Update: _____ (DR) _____

Update: _____ (DR) _____

Update: _____ (DR) _____

**PARENT/GUARDIAN & ADULT PATIENT
INFORMATION**

Your name _____
Last First M Mr Mrs Ms Dr
SS# _____ Birthdate ___/___/___

Employer _____

How long there? _____

Occupation _____

Work # _____ Ext _____

When & where are the best times to reach you? _____

Home address (if different from prior page)

City _____ State _____ Zip _____

Spouse's name _____

Last First M Mr Mrs Ms Dr
SS# _____ Birthdate ___/___/___

Employer _____

How long there? _____

Occupation _____

Work # _____ Ext _____

When & where are the best times to reach you? _____

Home address (if different from prior page)

City _____ State _____ Zip _____

**ORTHODONTIC INSURANCE
PRIMARY INSURANCE POLICY**

Orthodontic Coverage: yes no not sure

Insurance Co Name: _____

Insurance Co Street Address: _____

City _____ State _____ Zip _____

Insurance Co Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

SS# _____ Birthdate ___/___/___

Insured's Employer _____

SECONDARY INSURANCE POLICY

Orthodontic Coverage: yes no not sure

Insurance Co Name: _____

Insurance Co Street Address: _____

City _____ State _____ Zip _____

Insurance Co Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

SS# _____ Birthdate ___/___/___

Insured's Employer _____

I authorize the release of my dental records from Gilman Orthodontics to individuals involved in my dental care. I further authorize individuals involved in my dental care to release to Gilman Orthodontics any information pertaining to my dental care. I give my permission for the use of orthodontic records, which include photographs, radiographs, and study models, for the purpose of professional consultation, patient education, and research or publication in professional journals.

I understand that, where appropriate, credit bureau reports may be obtained. I hereby authorized the release of any information relating to all insurance claims for benefits submitted on behalf of myself and/or dependents. I agree that my signature on this document authorizes my dentist to submit claims for benefits for services rendered without obtaining my signature. We do not accept assignment of benefits.

I also acknowledge that I have reviewed Gilman Orthodontics' (HIPPA) Notice of Privacy Practices:

Print Name _____

Signature of Patient or Parent/Guardian _____ Date: _____