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
Nervous about orthodontic treatment
Recurring mouth sores
Gum Disease
Missing or extra teeth
Mouth breather
Speech problems
Tonsil or adenoid problem
Tongue or finger habit (stopped at age _____)
Injuries to face, mouth, or teeth
Jaw pain, locking, clicking or popping
Severe or frequent headaches
Grinding or clenching teeth
Leaning on chin or face
Lip, check or nail biting
Frequent gum chewing
Tooth extractions
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?

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 drugs 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
Hay fever
Blood Disorders
Abnormal bleeding
Anemia
Bruise easily
Diabetes/high blood sugar
Cancer/Chemotherapy/Radiation
Cortisone medication
Drug addiction
Ear trouble
Eye disorders
Glaucoma
Heart problems
Angina
Artificial heart valve
Congenital heart lesions
Heart attack
Heart surgery
Murmurs
Pacemakers
Rheumatic fever
Joint problems
Arthritis
Artificial joints
Rheumatism
Kidney trouble
Liver disease
Hepatitis
Yellow jaundice
Lung Disease
Emphysema
Tuberculosis(TB)
Muscle disorders
Nerve Disorders
Fainting or dizzy spells
Epilepsy or seizures
Psychiatric treatment
Stroke
Sinus troubles
Thyroid disease
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 office 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 _____

Wk # _____ 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: _____