Patient Information Form

Name ____ Date ______________
First Middle Last

Check Appropriate Box Male Female

Address ______________________ City ______________ State ________ Zip ________

Cell # ____________ Home phone ____________ Soc. Security # ______________ Birthdate __________

Email ____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Whom may we thank for referring you ____

Person to contact in case of an emergency ______________________ Phone ______________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient ______________

Address ______________________________________ Home phone ______________

Driver's license # ______________ Birth Date ______________ Soc. Security # ______________

Employer ______________________________________ Work phone ______________

Is this person currently a patient in our office Yes No

Dental Insurance Information

Name of insured ______________________________________ Relationship to patient ______________

Date of birth of insured ____________ Soc. Security # ______________ Date employed ______________

Name of employer ______________________________________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________________ Tel. # ____________ Grp. # ________ Policy/I.D.# __________

Do you have any additional dental insurance Yes No If yes, complete the following:

Name of insured ______________________________________ Relationship to patient ______________

Date of birth of insured ____________ Soc. Security # ______________ Date employed ______________

Name of employer ______________________________________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________________ Tel. # ____________ Grp. # ________ Policy/I.D. # __________

X ______________________________________

Signature of patient (or parent, if minor)

Medical History

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 or anything else that you know of? ___________________________
Yes No Do you have a history of a major illness?___________________________
Yes No Have you had any major operations?___________________________
Yes No Have you ever been involved in a serious accident?___________________________
Yes No For female patients: Do you think you may be pregnant?

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?___________________________
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Dental History

Dentist___________________________Date of last visit___________________________

What concerns you most about your teeth?___________________________

Yes No Are you presently in any dental pain? If yes, please explain ___________________________

Yes No Have you ever lost or chipped any teeth? If yes, please explain ___________________________

Yes No Have there been any injuries to face, mouth or teeth? If yes, please explain ___________________________

Yes No Do you have any type of thumb or tongue habit? If yes, type of habit and duration? ___________________________

Yes No Have you ever seen an orthodontist? If yes, who and when? ___________________________

Yes No Has anyone in your family received orthodontic treatment? If yes, when? ___________________________

Yes No Are you aware of your jaw clicking or popping? If yes, for how long? ___________________________

Yes No Have you ever been told that you grind your teeth? If yes, do you have a mouthguard? ___________________________

Yes No If the patient is under age 16, height of parents: Mom______ Dad______

Yes No Are you aware that some appointments will be during school/work hours?

Benefits and Consent

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. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Robert Gire, Associates, and Staff to perform a complete orthodontic evaluation.

X____

Signature of patient (or parent, if minor) **Date**