**Patient Information Form**

Name Date

First Middle Last

Address City State Zip

Cell # Home phone Soc. Security # Birthdate

Email

Preferred method of contact Cell Email Home Phone Work Phone Mail

Check Appropriate Box Minor Single Married Divorced Widowed Separated

If student, please provide the school’s name\_\_\_\_\_\_\_ City State

Patient or parent’s employer Work phone

Business address City State Zip

Spouse or parent’s name Employer Work phone

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

**Insurance Information**

Name of insured Relationship to patient

Birthdate Soc. Security # Date employed

Name of employer Union or local # Work phone

Employer address City State Zip

Insurance Co. Tel. # Grp. # Policy/I.D.#

How much is your deductible How much have you used Max annual benefit

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

Name of insured Soc. Security # Date employed

Name of employer Union or local # Work phone

Employer address City State Zip

Insurance Co. Tel. # Grp. # Policy/I.D. #

Ins. Co. address City State. Zip

How much is your deductible How much have you used Max annual benefit

**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?

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?

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

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

to perform a complete orthodontic evaluation.

Signature: Date: