Patient Information Form

lame	First	Middle		Last	-	Date
Address			City		State	Zip
Cell #						
Email						
Preferred method of contact		☐ Email		☐ Work Phone	☐ Mail	
Check Appropriate Box	☐ Minor	☐ Single	☐ Married	Divorced	☐ Widowed	☐ Separated
student, please provide the	school's name			City		State
atient or parent's employer						
usiness address		City		State	eZ	<u></u>
pouse or parent's name		Emplo	oyer	Work	phone	
hom may we thank for refe						
Person to contact in case of a						
Responsible Party				Relat	tionship to patier	nt
lame of person responsible	for this account					
				Hom	e phone	
ddress				<u>.</u>		
oddress Driver's license # Employer s this person currently a pati	ent in our office	Birth I	Date	Soc.	Security #	
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Name of person responsible address	ent in our office Ition Insurance Yes	Birth I Yes N Yes N Yes N In the least of the least o	Date lo lo or local # Tel. # complete the following Security # in or local # Tel. # Tel. #	Soc. Work Relate Date Work State Grp.	Security # tionship to patier employed the phone Max annua Pate employed Work phone State # F	Zip
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Medical History

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

Yes	No	Are you taking a	ny medication?						
Yes	No	No Are you allergic to any medication?							
Yes Yes	No No	Do you have a n	story or a major liness?						
Yes	No	Have you nad at	ny major operations?een involved in a serious accident?						
Circle	any of the	medical conditions b	pelow that you have had or currently	have.					
Abnorr	bnormal bleeding/Hemophilia		Diabetes	Hepatitis/Liver problems	Pneumonia				
	Anemia Arthritis Asthma or Hayfever		Dizziness	Herpes	Prolonged Bleeding Radiation/Chemotherapy Rheumatic Fever				
			Epilepsy	High Blood Pressure					
			Gastrointestinal Disorders	HIV / Aids					
	Disorders		Heart Problems	Kidney problems	Tuberculosis				
Conge	Congenital Heart Defect		Heart Murmur	Nervous Disorders	Tumor or Cancer				
Are the	ere any me	edical conditions we	have not discussed that you feel we	should be aware of?					
Den	tal His	tory							
Dentist	t			Date of last visit					
wnat c	oncerns y	ou most about your	teeth?						
Yes	No	Are you presently in any dental pain? If yes, please explain							
Yes	No	Have you ever lo	ost or chipped any teeth? If yes, plea	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 u	nder age 16, height of parents: Mor	m Dad					
Yes	No	Are you aware th	nat some appointments will be during	g 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: