GORDON ORTHODONTICS

PATIENT INFORMATION

Name ______ Today's Date ______

Street Address ______ City ______ State ______ Zip ______

Home Phone ______ Birthdate ______ Age ______ Male or Female

Siblings ______

If patient is a minor, give parent's or guardian's names ______

Whom may we thank for referring you to our office? ______

RESPONSIBLE PARTY INFORMATION

Name ______ Marital Status: ☐ Single ☐ Married ☐ Divorced

Address ______ # of Years ______ ☐ Rent ☐ Own

Previous address (if less than 3 years at current address) ______

Home Phone ______ Cell Phone ______ Work Phone ______

E-mail ______

Social Security # ______ Birthdate ______ Relationship to patient ______

Employer ______ Occupation ______ # years employed ______

Spouse's Name ______ Birthdate ______ Relationship to patient ______

Employer ______ Occupation ______ # years employed ______

Social Security # ______ Cell Phone ______ Work Phone ______

ORTHODONTIC INSURANCE INFORMATION

Primary Insured's Name ______ Insured's Birthdate ______ Insured's ID # ______

Insured's Address ______ Insured's Home Phone # ______

Insurance Company ______ Group # ______

Insurance Company Address ______

Insurance Company Phone # ______ Insured Employer ______

Do you have dual coverage? ☐ yes ☐ no If yes, please provide the following information:

Secondary Insured's Name ______ Insured's Birthdate ______ Insured's ID # ______

Insured's Address ______ Insured's Home Phone # ______

Insurance Company ______ Group # ______

Insurance Company Address ______

Insurance Company Phone # ______ Insured Employer ______

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you ______ Relationship to patient ______

Address ______ Phone # ______

I understand that where appropriate credit bureau reports will be obtained.

Signature (parent's signature if a minor) ______

For Staff Use Only: Reviewed by (date & initial) ______ ______ ______ ______ ______

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MEDICAL AND DENTAL HISTORY

Please circle all of the following conditions for which you have been diagnosed or treated:

Heart Trouble	Rheumatic Fever	Artificial Joints	Growth Disorder	Pregnancy
Hepatitis	AIDS or HIV+	Tuberculosis	Kidney Disorder	AADD/ADHD
Glaucoma	Asthma	Hormone Disorder	Depression	Latex Allergy
Blood Disorder	High Blood Pressure	Nervous Disorder	Diabetes	None of These

Any other medical conditions____

List any medications used____

List any allergies or drug reactions ____________________________________

Please circle YES or NO after the following questions:

Has there been any past injury to the face or teeth?	YES	NO
Is there any difficulty with speech?	YES	NO
Is it often difficult to breathe through your nose?	YES	NO
Are you aware of any missing or extra permanent teeth?	YES	NO
Do your gums ever bleed?	YES	NO
Do you have frequent headaches?	YES	NO
Does the jaw joint ever click or pop?	YES	NO
Does the jaw joint ever "catch" or feel restricted in its motion?	YES	NO
Does the jaw joint or jaw get sore or achy when chewing?	YES	NO
Do you grind or clench the teeth?	YES	NO
Have there been any oral habits, such as thumb or finger sucking, or tongue thrusting?	YES	NO

Your Dentist ______________________ Your Medical Doctor ______________________

In your own words, what is the primary problem for which you are coming to see us? ____________

Please give us any other information you feel might be helpful:______________________________

By signing below I hereby certify that the information given is accurate and complete to the best of my knowledge and I agree to inform the office immediately of any health status changes. I authorize the exposure of diagnostic x-rays when Dr. Gordon determines it is indicated.

Signature ______________________________________ Date______________

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