GORDON & DESANTIS
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 Gordon and DeSantis Orthodontics, LLC determine it is indicated.

Signature ____________________ Date____________________