Patient Information

Patient Last Name | Patient First Name | Prefers to Be Called | M/F

Patient DOB | Patient Age | Patient Soc. Sec. # | Patient Home # | Patient Cell #

Patient Street Address | Patient City, State Zip | Family E-Mail Address

Other Sibling/Child Full Name | M/F | DOB | Other Sibling/Child Full Name | M/F | DOB

Whom may we thank for referring you to our office? | If patient is a minor, parent or legal guardian name

Responsible Party Information

Resp. Party Last Name | Resp. Party First Name | Relationship to Patient

Resp. Party Street Address | City, State Zip | Resp. Party Home # | Resp. Party Cell #

How Long at Address | Marital Status: Single, Married, Divorced, Widowed, Separated

Resp. Party SSN | Resp. Party DOB | Resp. Party Employer | # Years at Employment

Resp. Party Spouse/Partner | Relationship to Patient | Resp. Party Spouse/Partner Cell #

Primary Dental Insurance Information

Insured's Last Name | Insured's First Name | Insured's Soc. Sec. # | Insured's DOB

Insurance Company | Insurance Co. Phone # | Insurance Co.'s Address | Insured's Employer

Emergency Information – Relative or Friend

Emergency Contact's Name | Cell # | Work # | Home #

Orthodontic	Dental	Medical
Has an orthodontist been previously consulted?	**Dentist Name:** **What was your dentist main concern?**	**Physician's Name:** **Date of last physical exam:**
In your own words, describe your orthodontic problems and what you would like orthodontics to accomplish?	**Is there any dental work needing to be completed prior to orthodontic treatment?** o **Yes** o **No**	**Has patient been under the care of a Physician in the last two years?** **If yes, please explain:**
Please tell us the patient's feelings toward orthodontic treatment? o **excited to get started** o **nervous/anxious** o **not committed to cooperate**	**Do you or have you ever required antibiotics needed for teeth cleanings?** o **Yes** o **No**	**List any medications being taken at this time:**
Hobbies/Comments:	**What was the date of patient's last cleaning?**	**List any drugs/things the patient is allergic to or has a reaction to:**

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please Check all that apply)

AIDS/HIV Infection	Chemotherapy	Frequent Cough	High Blood Pressure	Psychiatric Disease
Alcoholism	Cold Sores	Frequent Diarrhea	Hypoglycemia	Radiation Treatment
Alzheimer's Disease	Depression	Hay Fever	Intestinal Disease	Shortness of Breath
Anemia	Diabetes	Heart Attack/Failure	Jaundice	Sickle Cell Disease
Angina/Chest Pain	Dialysis	Heart Surgery	Joint Disease	Sinus Trouble
Arthritis	Dramatic Weight Loss	Heart Trouble/Disease	Kidney Problems	Stomach Disease
Asthma	Drug Addiction/Use	Hemophilia	Leukemia	Thyroid Disease
Blood Disease	Emphysema	Hepatitis A	Liver Disease	Tuberculosis
Breathing Problems	Excessive Bleeding	Hepatitis B	Low Blood Pressure	Ulcers
Bruise Easily	Excessive Thirst	Hepatitis C	Lung Disease	Venereal Disease
Cancer/Tumors	Fever Blisters	Herpes	Parathyroid Disease	No Medical Problems

PLEASE EXPLAIN ALL CHECKED RESPONSES: _____

ANY OTHER MEDICAL PROBLEM OR ILLNESS NOT CHECKED ABOVE PLEASE EXPLAIN_____

Consent: The undersigned hereby authorizes the doctor to take 3-D cone beam CT scans, x-rays, study models, photographs in order to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in medical status. I also authorize Dr. Gandy to utilize all diagnostic information gathered for educational, marketing, and insurance purposes.

Signature (Parent's signature if minor)	Date