GOOD+SEARS
ORTHODONTICS

260 Stockton St., Third Floor
San Francisco, CA 94108
415.399.9200 Tel
415.358.9800 Fax
www.goodsears.com

WELCOME TO OUR PRACTICE!

Please take a few minutes to complete the following information so we can better care for your orthodontic needs.

PATIENT INFORMATION

Patient's Name _____Birthdate_____ ☐ Male ☐ Female

Home Address _____ Home Phone _____

City _____ State _____ Zip _____ Mobile Phone _____

Occupation _____ Business Phone _____

Business Address _____

E-mail Address _____

Has any other member of the family been a patient at this office? Names: _____

Who may we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person responsible for account (Last, First, MI) _____

Relationship to patient _____ Birthdate _____ Soc. Security # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Responsible party employed by _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____ Insurance Phone _____

Insurance Company Address _____

Subscriber ID # _____ Group # _____

ADDITIONAL DENTAL INSURANCE

Insured Name (Last, First, MI) _____

Relationship to patient _____ Birthdate _____ Soc. Security # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Insured employed by _____ Business Phone _____

Insurance Company _____ Insurance Phone _____

Insurance Company Address _____

Subscriber ID # _____ Group # _____

Today's Date: _____ **ADULT HEALTH HISTORY** *(see reverse side)*

Patient Name _____ **Today's Date** _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under medical treatment?_____ Are you taking any medications? _____

Have you ever had any serious illness and/or operations? _____

Have you had allergic reactions to any drugs or medications? _____ If yes, which ones?_____

Do you have allergies to nickel or latex? _____Women: Are you pregnant? _____or trying to become pregnant?_____

Have you ever taken bisphosphonate medications (e.g. Fosamax, etc.)? _____

Please write *yes* on the line for each medical condition that applies:

_____ AIDS/HIV	_____ anemia	_____ arthritis/rheumatism	_____ artificial heart valves
_____ asthma/hayfever	_____bleeding problems	_____ blood disease	_____ bone disorders
_____ cancer	_____ diabetes	_____ emotional problems	_____ epilepsy/seizures
_____ fainting/dizzy spells	_____ frequent headaches	_____ frequent colds/flu	_____ heart problems
_____ hepatitis (type __)	_____ herpes	_____ high/low blood pressure	_____ kidney disease
_____ liver disease	_____ nervous problems	_____ pneumonia	_____ radiation treatment
_____ sinus problems	_____ stomach ulcer/reflux	_____ stroke	_____ thyroid problems
_____ tonsils/adenoids (if removed, age_____)		_____ vision/hearing problem	_____ other:

DENTAL HISTORY

Dentist's Name _____ Date of last visit _____

Date of last complete full mouth x-rays and/or panorex x-ray _____

Please write *yes* on the line for all that apply:

_____ bleeding gums	_____ blisters on lips/mouth	_____ prone to cavities
_____ missing teeth	_____ extra teeth	_____ any teeth extracted
_____ chewing difficulties	_____ speech difficulties (if so, please explain _____)	
_____ tooth grinding/clenching	_____ severe head and/or facial injuries, please explain _____	
_____ pain or clicking in the jaw joint (TMJ/TMD)		_____ jaw locking on opening or closing
_____ fingernail, cheek, or lip biting		_____ history of thumb/finger biting/sucking

_____ difficulty breathing through nose

_____ Have you ever consulted with an orthodontist? If so, when? _____

_____ Have you ever had orthodontic treatment? If so, when? _____

_____ Would you mind wearing braces to straighten your teeth?

What would you like orthodontic treatment to accomplish? _____

What concerns you most about orthodontic treatment:

_____ appearance _____ cost _____ length of time _____ pain _____effectiveness _____ other

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.
I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. I authorize release of any information regarding my treatment to my dental/medical insurance company. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical/dental health.

Signature _____ Date _____