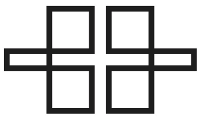

GOOD+SEARS
ORTHODONTICS

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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 _________________________
School/Grade____ E-mail _________________________
Sister(s)/Age(s) ______________________________________ Brother(s)/Age(s) ____

PARENTS / GUARDIANS

Name/Relationship___________________________________ Name/Relationship _____________________________________
E-mail ____ E-mail ____
Address ____ Address ____
City _________________________State ______ Zip ________ City _________________________State ______ Zip _________
Occupation ____ Occupation ____
Employer ____ Employer ____
Business Phone ______________________________________ Business Phone ____
Mobile Phone ____ Mobile Phone ____
Does the patient live with both parents? __________ If no, please elaborate ____
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: _______________ **CHILD (UNDER 18) HEALTH HISTORY** *(see reverse side)*

Patient Name ___________________________________ **Today's Date** ___________________

MEDICAL HISTORY

Physician's Name ____ Date of Last Visit __________________________

Is the patient currently under medical treatment?_______ Is the patient taking any medications? ________________________

Has the patient ever had any serious illness and/or operations? ____

Has the patient had allergic reactions to any drugs or medications? _____ If yes, which ones?____________________________

Does the patient have allergies to nickel or latex? ___________ (Women only) Is the patient pregnant? ___________________

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

_______ ADD	_______ AIDS/HIV	_______ anemia	_______ arthritis/rheumatism
_______ artificial heart valves	_______asthma/hayfever	_______ bleeding problems	_______ blood disease
_______ bone disorders	_______ cancer	_______ diabetes	_______ emotional problems
_______ epilepsy	_______ fainting/dizzy spells	_______frequent headaches	_______ frequent colds/flu
_______ heart problems	_______ hepatitis-type __	_______ herpes	_______ high/low blood press
_______ kidney disease	_______ liver disease	_______ motor difficulties	_______ nervous problems
_______ pneumonia	_______ radiation treatment	_______ sinus problems	_______ stomach ulcer/reflux
_______ stroke	_______ thyroid problems	_______ tonsils/adenoids . . . if removed, age_____	
_______ Tourette's	_______ tuberculosis	_______ 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 ________________________________