Gulf Coast ORTHODONTICS

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We would like to welcome you to our office. In an effort to provide the best service possible, we ask that you fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Adult

Patient's Name _____ Age_____ Birth Date_____

Nickname (if preferred) _____ Male Female

Cell Phone _____ Cell Provider _____ SS #_____

Home Address _____ City_____, State_____, ZIP_____

Employer _____ Employer Address_____

Occupation _____ How Long? _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? YES NO If YES, Name _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have you visited an orthodontist before? YES NO If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? YES NO

Dental Insurance Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Primary

Insurance Company Name_____ Insurance Company Phone # _____

Insurance Company Address_____ Group or plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Secondary

Insurance Company Name_____ Insurance Company Phone # _____

Insurance Company Address_____ Group or plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Dental and Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? _____

Physician's name _____ Phone # _____

History of major illness? YES NO If YES, please describe _____

Any sensitivities or allergies? YES NO If YES, please list _____

Currently taking any medications? YES NO If YES, please list_____ Amount/Dose _____

Have you been treated for any of the following?

Arthritis Blood Disorder Diabetes Heart Condition Tuberculosis

Asthma Cancer Epilepsy Nervous Disorder High Blood Pressure

Celiac Disease

Do you require antibiotics before dental treatment? YES NO If YES, Explain_____

Have there been injuries to your face, mouth, or chin? YES NO

Have you ever had pain/tenderness in the jaw joint? (TMJ/TMD) YES NO

Do/Did you have any the following habits?

Grinding Teeth Finger/Thumb Sucking Tongue Thrusting

Chronic Mouth Breathing Speech Problems Chewing/Eating Problems

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____ Date_____

Email Address: _____