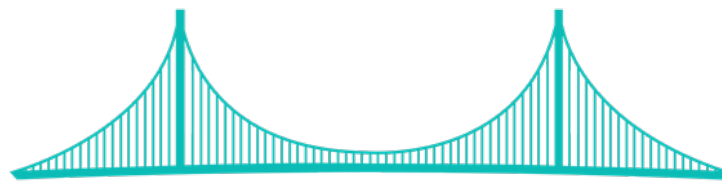

Patient Information and Health History

Please check your preferred location for appointments: ☐ **Gig Harbor** ☐ **Tacoma**

Patient First Name:		Last Name:			Today's Date:
Patient Preferred Name:	Height:	Weight:	Date of Birth:	Age:	Gender:
Permanent Mailing Address: Temporary Mailing Address:					*Text messages ok? Yes No* Home Phone: ( ) - ☐ ☐ Cell Phone: ( ) - ☐ ☐ Work Phone: ( ) - ☐ ☐
Email Address:			Have any family members had treatment at our office?		
Employer:			Occupation:		
Who may we thank for referring you to our office?			**How did you hear about our office?**		

Financially Responsible Party Information

Print Full Name (If differs from above):	Relationship to Patient:	Date of Birth:
Email Address:		SSN:
Permanent Mailing Address: Temporary Mailing Address:		*Text messages ok? Yes No* Home Phone: ( ) - ☐ ☐ Cell Phone: ( ) - ☐ ☐ Work Phone: ( ) - ☐ ☐
Primary Dental Insurance Company:		Dental Insurance Phone:
Primary Policy Holder's Full Name:	Employer:	Relationship to Patient:
Group/Plan#:	Occupation:	Date of Birth:
Policy Holder ID#:		SSN:
Mailing Address (If differs from above):		*Text messages ok? Yes No* Home Phone: ( ) - ☐ ☐ Cell Phone: ( ) - ☐ ☐ Work Phone: ( ) - ☐ ☐
Secondary Dental Insurance Company:		Dental Insurance Phone:
Secondary Policy Holder's Full Name:	Employer:	Relationship to Patient:
Group/Plan#:	Occupation:	Date of Birth:
Policy Holder's ID#:		SSN:
Mailing Address (If differs from above):		*Text messages ok? Yes No* Home Phone: ( ) - ☐ ☐ Cell Phone: ( ) - ☐ ☐ Work Phone: ( ) - ☐ ☐

Dental History		
Dentist's Name:	Date of last dental appointment:	Dentist's concerns:
Any prior trauma/injury to face/mouth?	If yes, explain:	
Any history of jaw problems (TMJ/TMD)?	If yes, explain:	
Any history of the following? ☐Grinding/Clenching teeth ☐Mouth-breather ☐Tongue Thrust ☐Chewing/eating problems ☐Speech problems ☐Other ____________________		
Are you currently in orthodontic treatment? If yes, who is your orthodontist?		
Have you visited an orthodontist before?	Have any other family members received orthodontic treatment?	
What are your chief concerns?		

Medical History	
Physicians Name:	Describe overall health. Circle: Excellent / Good / Fair / Poor
Are you currently under the care of a physician? If yes, explain.	

Please circle "Y" for Yes, or "N" for No, regarding your history of the following:

Y N Abnormal Bleeding	**Y N** Hearing Impairment	**Y N** Headaches/Neck aches	**Y N** Radiation Treatment
Y N Heart Murmur	**Y N** Kidney Problems	**Y N** HIV or AIDs Related Complex	**Y N** Cancer:__________
Y N Allergies to Latex/Metals	**Y N** High Blood Pressure	**Y N** Thyroid Problems	**Y N** Diabetes
Y N Tonsils/Adenoids removed	**Y N** Arthritis	**Y N** Osteoporosis	**Y N** Bone Density Problems
Y N Allergies/Asthma	**Y N** Liver Problems/Hepatitis	**Y N** TB	**Y N** Rheumatic/Scarlet Fever
Y N Emotional/Psychiatric care	**Y N** Pregnancy (month #____)	**Y N** Other: ____	

If yes to any of the above, please explain.
List all medications you are currently taking:
List any drugs you are allergic to:
Do you require antibiotics before dental treatment?

Insurance: To avoid a misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for the total professional fee. We submit insurance as a courtesy to our patients, but it is in no way a guarantee of payment from the insurance company.

Confidentiality: All information contained on this form will remain strictly confidential. I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Consent to Examination and Treatment: I am choosing to be examined and treated at Gig Harbor - Tacoma Orthodontics. I understand that treatment will consist of diagnostic x-rays, photos, exam by the doctor, and impressions (molds). My signature below signifies that I understand the above statements and consent to examinations and treatment by the doctor and by the doctor's staff under her direct supervision and instruction.

Signature: ____ **Today's Date**: ____________________