GIG HARBOR - TACOMA
ORTHODONTICS
DR. PATRA ALATSIS

Patient Information and Health History

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

Patient's First Name:		Last Name:			Today's Date:
Patient's Preferred Name:	Height:	Weight:	Date of Birth:	Age:	Gender:
Patient's Mailing Address:			City:	State:	Zip Code:
Patient's School:		Grade:	Patient's Hobbies/Interests:		

Patient's Siblings (Name, Birth Year):	*History of braces?* *Yes*	*No*	Patient's Siblings (Name, Birth Year):	*History of braces?* *Yes*	*No*
1.) _____	☐	☐	4.) _____	☐	☐
2.) _____	☐	☐	5.) _____	☐	☐
3.) _____	☐	☐	6.) _____	☐	☐

Who may we thank for referring you to our office?	**How did you hear about our office?**

Responsible Party Information

Primary Responsible Party's Full Name:	**Relationship to Patient:**	**Spouse's Full Name:**	**Relationship to Patient:**
Complete Mailing Address:		Complete Mailing Address:	

DOB:		*Text messages ok?* *Yes*	*No*	DOB:		*Text messages ok?* *Yes*	*No*
	Home Phone:	( ) -	☐ ☐		Home Phone:	( ) -	☐ ☐
SSN:	Cell Phone:	( ) -	☐ ☐	SSN:	Cell Phone:	( ) -	☐ ☐
	Work Phone:	( ) -	☐ ☐		Work Phone:	( ) -	☐ ☐
Employer:	Occupation:			Employer:	Occupation:		
Email:				Email:			

Secondary Responsible Party's Full Name:	**Relationship to Patient:**	**Spouse's Full Name:**	**Relationship to Patient:**
Complete Mailing Address:		Complete Mailing Address:	

DOB:		*Text messages ok?* *Yes*	*No*	DOB:		*Text messages ok?* *Yes*	*No*
	Home Phone:	( ) -	☐ ☐		Home Phone:	( ) -	☐ ☐
SSN:	Cell Phone:	( ) -	☐ ☐	SSN:	Cell Phone:	( ) -	☐ ☐
	Work Phone:	( ) -	☐ ☐		Work Phone:	( ) -	☐ ☐
Employer:	Occupation:			Employer:	Occupation:		
Email:				Email:			

Insurance Information		
Primary Dental Insurance Company:	Dental Insurance Phone:	Group/Plan#:
Primary Policy Holder's Full Name:	Policy Holder's ID:	Policy Holder's Date of Birth:
Secondary Dental Insurance Company:	Dental Insurance Phone:	Group/Plan#:
Secondary Policy Holder's Full Name:	Policy Holder's ID:	Policy Holder's Date of Birth:

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 ☐ Chewing/eating problems ☐ Finger/Thumb habit ☐ Mouth-breather ☐ Speech problems ☐ Tongue thrust		
Are you currently in orthodontic treatment? If yes, who is your orthodontist?		
Have you visited an orthodontist before?	Have other family members received orthodontic treatment (besides siblings already listed)?	
What are your chief concerns?	Are there any esthetic or psycho-social concerns (ie – teasing, self-esteem… ?)	

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 any 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 Problems/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 digital 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**: _____

Our office is committed to meeting/exceeding the standards of infection control mandated by OSHA, the CDC and the American Dental Association.