Date: _____

PATIENT INFORMATION - ADULT

Full Legal Name: _____ Gender: _____

Nickname: _____ Hobbies: _____

Date of Birth: _____ Age: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Home Mailing Address: _____
Street address, city, state, zip

Occupation:_____ Employed by:_____

Length of employment:_____ Business Phone:_____

Do you own or rent your home?_____ For how long?_____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Partnered ___ Widowed

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone:_____

GENERAL INFORMATION

Whom should we thank for referring you to our office? _____

Have you visited our Website?___ Do you use Facebook, Google Reviews, or Yelp Reviews? (Circle all that apply)

Which search engine do you prefer to use (Google, Bing, Explorer, Yahoo)? _____

Has anyone else in your family had orthodontic treatment? _____

Do you have any special needs or sensory issues?_____

DENTAL INSURANCE INFORMATION

Name of policy holder: _____ Policy holder's SS#: _____

Policy holder's date of birth: _____ Insurance Company Name:_____

Insurance Company Address: _____

Employer Name: _____ Insurance Phone #: _____

Policy holder ID#: _____ Group #: _____

PATIENT MEDICAL HISTORY

Current Primary Care Dentist: _____ __Don't have one __I don't remember

Last dental appointment: __Less than 6 months ago __6-12 months ago __More than 12 months ago

Is the patient pregnant? __Unsure __No __Yes Is the patient under the care of a physician? __No __Yes

Are you taking any medications? _____

Is the patient currently taking or has ever taken a bisphosphonate? Or any medication to make bones stronger, such as: Actonel, Aredia, Boniva, Fosamax, Didronel, Skelid, Zometa, other: _____

For **orthodontic treatment**, please let us know if the patient has (check all that apply):

__ Been evaluated for orthodontic treatment before
__ Had the tonsils or adenoids removed
__ Ever received an injury to the face, mouth, teeth or chin
__ Difficulty breathing
__ Had any pain or clicking sounds in the jaw joint (TMJ)
__ Ever broken a tooth
__ Been told to take an antibiotic prior to dental visits
__ Had problems with previous dental work

Does the patient have any of the following **medical conditions**?

__ **NO MEDICAL CONDITIONS**

__ Abnormal bleed	__ Cancer	__ Endocrine/growth disorders	__ Hepatitis
__ Abnormal breathing	__ Chronic sinus problems	__ Handicaps/disabilities	__ HIV/AIDS
__ ADD/ADHD	__ Congenital heart disease	__ Hearing impairment	__ Hospitalizations
__ Artificial bones/joints	__ Convulsions/epilepsy	__ Heart murmur	__ Kidney/liver problems
__Autism/Asperger's	__ Diabetes	__ Hemophilia/blood disorders	__ Lupus

Allergies (check all that apply): __**NO ALLERGIES** __ Antibiotics __Aspirin __Codeine __Dental Anesthetics __Latex __Metal __Plastic

Please list any other allergies: _____

Please describe any serious medical problems the patient has experienced: _____

Has the patient ever had any of the following habits (check all that apply)?

__Clenching/Grinding Teeth __Mouth Breathing __Nail Biting __Lip Sucking __Thumb Sucking __Difficulties with Speech

__Tobacco Use __ Tongue Thrust __Snoring Chews on Ice / Pens / Pencils / Water Bottles __ **None of the Above**

Dental Hygiene (check all that apply): __Brush twice a day __Floss regularly __Gums Bleed __Taking Fluoride Supplements

Please list any other dental concerns that may be helpful:_____

CONFIRM

I confirm that the information I have provided about the patient or myself is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in medical status that occur after this date. I authorize Dr. Garcia and his team to perform an initial orthodontic examination and any necessary dental services that I or the patient may need during diagnosis and treatment with my informed consent.

Signature_____ Date_____

(You will sign this at your appointment)

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

Join Dr. Garcia's Kids' Club

About our Kids' Club……

- Dr. Garcia is trained to spot subtle problems with jaw growth and emerging teeth while some baby teeth are still present.
- As a preventative orthodontic office, Dr. Garcia likes to examine children by age 7 to track growth patterns.
- Usually, no orthodontic treatment will be needed at this time and with that good news, Dr. Garcia will place your child in our program where he will continue to monitor their growth and development at no charge. This service is completely complimentary.
- If your child has not yet reached their 7th birthday, we will keep their name in our system and when their 7th birthday approaches, we will contact you regarding setting up their complimentary evaluation.

List any family member you would like to receive an initial examination at age 7.	
Name	**Date of Birth**
Additional family member over the age of 7 you would like to receive a complimentary examination in the near future.	
Name	**Date of Birth**

Welcome to our orthodontic family. It is our honor and privilege to provide you with the finest orthodontic care while creating your beautiful new smile!

Sincerely,

Dr. Garcia