BRACES BY garcia

WELCOME TO OUR OFFICE!

Who Are We Seeing Today?

How did you find out about us? _____

Patient's Full Name:_____ Date of Birth:_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number:_____ Work Phone Number: _____

Email: _____ Social Security #: _____

Patient's School Name: _____

Who is your Dentist? _____ Dentist Phone #:_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone #: _____

Would you like to get braces *today*? _____

Responsible Party Information ~ Are you also the Patient? YES NO

If you are the Patient, leave the Responsible Party Information Blank

Full Name: _____ Date of Birth:_____

Phone #:_____ Secondary Phone #:_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ Social Security #: _____

Insurance Information

Insurance Company: _____ Employed by: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth:_____

TURN OVER

Group Number: _____ Policy Holder's ID: _____

Secondary Insurance Information

Insurance Company:_____ Employed by: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Group Number:_____ Policy Holder' ID #: _____

Please Circle Yes or No to the Following Questions:

Have you seen a dentist in the last six months? YES NO

Any cavities or gum problems that need treatment or have been treated? YES NO

If so, please explain: _____

Any injuries to the teeth, jaws or head? YES NO

If so, please explain: _____

Circle any of the following habits the patient may have:

Clenching / Grinding Teeth, Mouth Breathing, Nail Biting, Speech Problems, Chews on Ice / Pens / Pencils

- ❑ None of the above

Seeing a physician? YES NO

Are there any medical, psychiatric, physical or other health conditions that required past or ongoing medical doctor visits and/or treatment? YES NO

If so, please explain:_____

Do you take any prescription or over-the-counter medications? YES NO

If so, please explain: _____

Do you have any allergies? YES NO

If so, please explain: _____

Are you pregnant or is there a chance you are pregnant? YES NO

Confirmation

I understand that the information I have provided about the patient and or/myself is correct to the best of my knowledge and that it is my responsibility to inform the office of any changes in medical status that occur after this date. I authorize Braces By Garcia 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: _____

Thank you for filling out this form completely!