GRIFFIN ORTHODONTICS PATIENT INFORMATION

Date_____

Patient's name: _____ Nickname:_____
Last First Middle

Address_____
Street City Zip

Birthdate_____School/Grade_____Sports/Hobbies _____

Parent or guardian name _____

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

RESPONSIBLE PARTY INFORMATION

Responsible Party #1 NAME_____Relationship to Patient: _____

Address_____
Street City Zip

Phone:_____ Birthdate_____ Social Security #_____

Email Address _____ Cell Phone Carrier (to Receive Text) _____

Employer_____ Occupation_____ Years Employed _____

Responsible Party #2 NAME_____ Relationship to Patient: _____

Address:_____
Street City Zip

Phone:_____ Birthdate:_____ Social Security # _____

Email Address_____ Cell Phone Carrier (to Receive Text)_____

Employer_____Occupation_____ Years Employed _____

DENTAL INSURANCE INFORMATION

Policy Holder Name: _____DOB:_____ Policy Holder SS# _____

Insurance Company:_____ Member #: _____

Group #: _____ Employer Name:_____

Insurance Co. Address (Claims): _____Effective Date: _____

Do you have dual coverage? Yes_____ No_____ If yes:

Policy Holder Name: _____DOB:_____ Policy Holder SS#: _____

Insurance Company:_____ Member #_____

Group #_____ Employer Name: _____

Insurance Co. Address (Claims):_____Effective Date: _____

EMERGENCY INFORMATION

Contact Name / Relationship: _____

Phone _____

By signing, you agree that the information above is correct.

Patient/Parent Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician Name: _____Date of Last Visit _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Is the patient pregnant? _____

Is the patient allergic to anything? If Yes, Please List:_____

Circle any of the medical conditions below that the patient has had or currently has:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? If Yes, please explain:

_____

_____

DENTAL HISTORY

General Dentist_____ Date of last visit _____

Address / Location _____

What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry?_____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do gums bleed when brushing?_____
How are patients oral hygiene habits?_____
Yes No Any type of thumb or tongue habit? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
What is the patient's attitude toward receiving orthodontic treatment?_____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping?_____
Yes No Aware of clenching or grinding teeth during the day?_____
Yes No Experience "tension" headaches? _____
Yes No **Are you aware that some appointments will be during school/work hours?** _____

Is there anything else we should be aware of? _____

_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize **Dr. David Griffin DDS** to perform a complete orthodontic evaluation.

Signature: _____ Date: _____