GRINBAUM ORTHODONTICS

PATIENT INFORMATION

Date_____

Patient'sName_____
Last First Middle

Address_____
Street City Zip

Home Phone _____Birthdate_____Age: (___) Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

E-Mail Address: _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Residence_____
Street City Zip

Mailing Address_____
Street City Zip

How long at this address? _____ Home phone_____ Work phone_____

Cell/other phone_____ Email address _____

Social Security #_____ Birthdate_____

Relationship to Patient _____

Employer_____Occupation_____

Spouse's Name_____ Relationship to Patient _____

Employer_____Occupation_____

Social Security #_____Birthdate_____

DENTAL INSURANCE INFORMATION

Insured's Name _____Insured's Social Security or ID # _____

Insurance Company _____Group No._____

Insurance Co. Address _____Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes complete below:

Insured's Name _____Insured's Social Security # _____

Insurance Company_____ Group No._____

Insurance Co. Address _____Phone No. _____

EMERGENCY INFORMATION

Name of emergency contact _____

Complete address_____
Street City Zip

Phone _____May we contact this person in case of emergency? Yes___No____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____Phone _____

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any medical conditions that you currently or previously have

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

Are there any medical conditions we have not discussed that you feel we should be aware of?
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____
Yes No Are you presently in any dental pain?
Yes No Have you ever had an unfavorable reaction to dentistry?
Yes No Have you 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/Pressure?
Yes No Do your gums bleed when you brush?
Yes No Do you have any type of thumb or tongue habit?
Yes No Are you a mouth breather?
Yes No Have you ever seen an orthodontist? If yes, who/when? _____
Yes No Do you ever have pain in your teeth or jaws when you wake up?
Yes No Are you aware of your jaw clicking or popping?
Yes No Are you aware of clenching/grinding your teeth?
Yes No Do you have “tension” headaches?
Yes No Have you ever experienced chronic ringing in your ears?
Yes No If the patient is under age 16, height of parents? Mom _____Dad_____
Yes No Are you aware that some appts will be during school/work hours?

Female Patients Only:

Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

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. Grinbaum to perform a complete orthodontic evaluation.

Signature: _____Date_____