Welcome! We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Name _____ Social Security #_____
Last First Initial

Address _____

City _____ State _____ Zip _____ Home Ph _____

Alternate Phone (circle one: cell / work) _____ Email _____

Sex M ☐ F ☐ Age_____ Birth Date____/___/_____ (Martial Status Circle One) Single Married Widowed Separated Divorced

Whom may we thank for referring you? _____

Notify in case of emergency: _____ Emergency Contact Phone: _____

Person responsible for Acct: _____ Relation to Patient: _____

Responsible Party Birth Date: ____/____/_____ SS#: _____ Phone Number: _____

Address (if different from patient) _____

Responsible Party Employed By: _____ Occupation: _____

Employer Address: _____

Insurance Company: _____ Insurance Phone #: _____

Group #: _____ Subscriber #: _____ Contract #: _____

Name(s) of other dependents under this plan: _____

Please complete both sides

Dental History

What concerns do you have about your smile? _____

Dentist: _____ Date of last visit to dentist? _____ Date of last x-rays? _____

Check if you have problems with any of the following:

☐ Bad Breath	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your smile? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Medical History

Physician's Name: _____ Phone: _____

Are you currently under physician care? ☐Y ☐N Have you ever had a blood transfusion? ☐Y ☐N Have you ever taken Fen-Phen/Redux ☐Y ☐N

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking Birth Control Pills ☐Y ☐N

Check if you have had any of the following:

☐ AIDS/HIV Positive	☐ Circulatory problems	☐ Hemophilia/Abnormal Bleeding	☐ Pacemaker/heart surgery	☐ Surgical implant
☐ Anaphylaxis	☐ Cortisone treatments	☐ Herpes	☐ Psychiatric care	☐ Swelling of feet or
☐ Anemia	☐ Cough, persistent	☐ Hepatitis	☐ Rapid weight gain/loss	Ankles
☐ Arthritis, Rheumatism	☐ Cough up blood	☐ High blood pressure	☐ Radiation Treatment	☐ Thyroid disease or
☐ Artificial heart valves	☐ Diabetes	☐ Jaw pain	☐ Respiratory disease	Malfunction
☐ Artificial joints	☐ Epilepsy	☐ Kidney Disease or	☐ Rheumatic/Scarlet	☐ Tobacco Habit
☐ Asthma	☐ Fainting	Malfunction	fever	☐ Tonsillitis
☐ Atopic (allergy prone)	☐ Food allergies	☐ Liver Disease	☐ Shingles	☐ Tuberculosis
☐ Autism	☐ Glaucoma	☐ Material allergies	☐ Shortness of breath	☐ Ulcer/Colitis
☐ Back problems	☐ Headaches	(**LATEX,** wool, metal,	☐ Skin Rash	☐ Venereal Disease
☐ Blood disease	☐ Heart Murmur	chemicals)	☐ Spina Bifida	☐ Other
☐ Cancer	☐ Heart problems	☐ Mitral valve prolapse	☐ Stroke	Describe:_____
☐ Chemical Dependency	Describe: _____	☐ Nervous problems		_____
☐ Chemotherapy				

Is patient currently taking any medications? If yes, list all: _____

Does Patient have drug allergies? If yes, list all: _____

Authorization:

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the Orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the Orthodontist.

I authorize the insurance company indicated on this form to pay Grayson Orthodontics LLC all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____