GARRETT ORTHODONTICS
GO for that perfect smile

Date: ____/____/____

Patient Information

Patient's name: _____ ____ _____ Sex: ☐ M ☐ F
First MI Last

Nickname/Preferred name you would like to be called: _____

Address: _____ _____ _____
Street City Zip

Birth Date: ____/____/____ Age: _____

Main Phone(**): _____ Cell Phone: _____

(**) This is the # we contact for HouseCalls appointment reminders, billing, etc.

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

How did you first hear about our office? _____

Please list other family members seen at this office and their relationship to this patient: _____

Personal Information (Child)

School:_____ Grade: _____

Hobbies & Interests:_____

Brothers/Sisters (ages):_____

Responsible Party Information

Name: _____ ____ _____
First MI Last

Address (if different): _____ _____ _____
Street City Zip

Relationship to patient: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer: _____ Occupation: _____

Main(**) phone:_____ Work phone: _____ Cell phone:_____

Email address (for T.Link billing statements, appointment reminders, etc.): _____

Spouse's Name: _____ ____ _____
First MI Last

Relationship to patient: _____

Employer: _____ Occupation: _____

Home phone:_____ Work phone:_____ Cell phone:_____

Patient lives with: ☐ Both Parents Together ☐ Both Parents Separately ☐ Mother ☐ Father ☐ Adult (N/A)

Dental Insurance Information

Primary Insurance Company _____ Group/Plan/Local No._____

Insurance Co. Address_____ Phone No. _____

Policy Owner's Name_____ Birth Date: ____/____/____ Social Security #_____-_____-_____

* Do you have dual coverage? ☐ Yes ☐ No If yes, complete below:

Secondary Insurance Company _____ Group/Plan No. _____

Insurance Co. Address_____ Phone No. _____

Policy Owner's Name_____ Birth Date: ____/____/____ Social Security #_____-_____-_____

Medical History

Physician: _____ Date of Last Visit: _____

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

Yes	No	
☐	☐	Is the patient in good health? _____
☐	☐	Is the patient taking any medication? Please list: _____
☐	☐	Is the patient allergic to any medication? Please list: _____
☐	☐	Has the patient ever been involved in a serious accident? Explain: _____
☐	☐	Does the patient now or has he/she ever taken Bisphosphonates? (i.e. Fosamax, Zometa, Boniva, Aredia, Actonel, etc) If yes, which drug? _____

Female Patients only:

Yes	No	
☐	☐	Has menstruation begun? At what age? _____
☐	☐	Are you pregnant? If yes, what is the due date? _____

Does the patient have or has he/she had any of the following diseases or conditions? (check Yes or No)

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding/Hemophilia	☐	☐	Heart Defect, Murmur, or Disease	☐	☐	Nervous Disorders
☐	☐	Arthritis	☐	☐	Hepatitis (If yes, circle A B C)	☐	☐	Radiation/Chemotherapy
☐	☐	Asthma	☐	☐	Herpes/Fever Blisters ❒	☐	☐	Rheumatic Fever
☐	☐	Bone Disorders	☐	☐	High or Low Blood Pres	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	HIV / Aids	☐	☐	Tumor or Cancer
☐	☐	Fainting or Dizziness	☐	☐	Joint Replacement or Implant	☐	☐	Tonsils/Adenoids removed
☐	☐	Epilepsy	☐	☐	Latex or Nickel Allergy/Sensitivity			

Are there any medical conditions, diseases or problems not discussed that you feel we should be aware of?

_____

Dental History

General Dentist: _____ Date of last visit: _____

What are the main concerns you would most like orthodontics to address? _____

Patient's attitude towards orthodontic treatment: ☐ Very Motivated ☐ Will Cooperate (if needed) ☐ Not Motivated

Yes	No	
☐	☐	Is the patient experiencing any dental problems/pain? _____
☐	☐	Have there been any injuries to: (select all that apply) ❒ Face ❒ Mouth ❒ Teeth
☐	☐	Has an orthodontist been consulted previously? Reason: _____
☐	☐	Are you aware that some appointments will be during school/work hours?

Does the patient have or has he/she had any of the following diseases or conditions? (check Yes or No)

Yes	No		Yes	No		Yes	No	
☐	☐	Tongue Thrust habit	☐	☐	Missing Permanent Teeth	☐	☐	Permanent Tooth extraction
☐	☐	Finger/Thumbsucking habit	☐	☐	Extra Permanent Teeth	☐	☐	Fear of Dental Work
☐	☐	Fingernail biting	☐	☐	Jaw Pain (TMJ/TMD)	☐	☐	Clenching/Grinding
☐	☐	Mouthbreather	☐	☐	Jaw Joint clicking/popping	☐	☐	Previous Orthodontic Therapy

I acknowledge that the above information is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform Dr. Garrett of any changes that occur after this date. I hereby authorize Dr. Garrett and his team to take x-rays and perform a complete orthodontic evaluation/examination. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____ **Date:** _____
(Patient or Guardian)

Treatment Options:

1) _____

_____

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