GAST & NIELSEN ORTHODONTICS

ORTHODONTICS FOR ALL AGES

Patient Number ______

Date ______

PATIENT INFORMATION

Name: ______ Birthdate: ______ Age: ______ Sex: ______

Address: ______ City: ______ State: ______ Zip: ______

Phone: ______ If Student, School Name: ______

Sports or Hobbies: ______

COMPLETE FOR ADOLESCENT PATIENT

PARENT/GUARDIAN INFORMATION

Name

Address

City State Zip

Home Phone Work Phone.

Email Address

PARENT/GUARDIAN INFORMATION

Name

Address

City State Zip

Home Phone Work Phone.

Email Address

Responsible Party

Billing Address

PRIMARY DENTAL INSURANCE

❒ Check here if coverage includes orthodontic benefits

Subscriber Name

Employer Name

Occupation

Birthdate Age Sex Marital Status

Subscriber #

Group #

Insurance Company Name

Insurance Address

Insurance City State Zip

Insurance Phone Ext.

SECONDARY DENTAL INSURANCE

❒ Check here if coverage includes orthodontic benefits

Subscriber Name

Employer Name

Occupation

Birthdate Age Sex Marital Status

Subscriber #

Group #

Insurance Company Name

Insurance Address

Insurance City State Zip

Insurance Phone Ext.

OTHER INFORMATION

Dentist Name

Physician Name

Who may we thank for referring you?

Other Children Birthdate

Other Children Birthdate

Other Children Birthdate

12/15

Please Complete Backside

MEDICAL INFORMATION

	YES	NO
Any Heart Disease:		
Any Respiratory Disease:		
Any Blood Disease:		
Any Liver Disease:		
Any Thyroid Disease:		
Any Kidney Disease:		
H.I.V. Positive:		
Any Venereal Disease:		
Any Intestinal Disease:		
Any Bone Disease:		
Any Nervous/Emotional Problems:		
Any High or Low Blood Pressure:		
Any Endocrine Problems:		
Any Problems with Wounds Healing:		
Any Tumors or Cancer:		

	YES	NO
Rheumatic/Yellow/Scarlet Fever:		
Acquired Immune Deficiency Syndrome:		
Is the Patient Under Medical Care:		
Rheumatism or Arthritis:		
Is the Patient taking any Medications:		
A History of Fainting or Dizziness:		
Does the Patient have a Drug Addiction:		
Is the Patient Pregnant at this Time:		
Measles/Mumps/Chicken Pox:		
Does the Patient Smoke:		
Has the Patient ever had Fever Blisters:		
Is Height & Weight Normal for Age:		
Is the Patient in Good Health:		
Has the Patient had a Physical this Year:		
Has the Patient Reached Puberty:		

	YES	NO
Heart Murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		

	YES	NO
Asthma or Hay Fever:		
Tuberculosis:		
Any Broken Bones:		
Prolonged Bleeding:		
Yellow Jaundice:		
Radiation Therapy:		
Chemical Therapy:		
Blood Transfusions:		
Latex Allergy:		
Is the Patient Allergic to Anything:		

What: ______________________

List any Medications: ______________________

Are you aware of any other disease, condition, or problem not listed above that we should know about:

If Yes, What: ______________________

DENTAL HISTORY

	YES	NO
Has the Patient Seen a General Dentist in the Last Year:		
Any Pain, Clicking or Discomfort In or Near the Ears:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Have You Been Informed of Missing or Extra Permanent Teeth:		
Are You Aware of Any **"Gum"** Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		
Would the Patient Mind Wearing **"Braces"**:		

Does the Patient Have or Ever Had Any of the Following Habits:

	YES	NO
Cheek, Tongue or Lip Chewing:		
Thumb Sucking:		
Mouth Breathing:		
Finger Nail Biting:		

	YES	NO
Clenching Teeth:		
Tongue Thrusting:		
Grind Teeth:		
Speech Problems:		

	YES	NO
Has the Patient Been Examined by an Orthodontist Before:		
If Yes, When:		
Have Other Members of the Family had Orthodontic Treatment:		
If Yes, Were You Happy With the Results:		

If No, Why: ______________________

In Your Own Words What is the Orthodontic Problem: ______________________

What Would you Like Orthodontic Treatment to Accomplish: ______________________

FOR OFFICE USE ONLY

X-Rays: Lab	X-Rays: Dentist	Date:	Procedure:	Appt.:
Problem:				
Tentative TX:				