

All information is protected by federal laws • All information must be provided prior to consultation.

Confidential Patient Information

Patient's Name _____ Male Female
Last First Middle

Address _____
Street City State Zip

Home Phone (_____) _____ **Birthdate** _____ **Age** _____ **Social Security #** _____

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

Name of General Dentist _____ **Date of last cleaning** _____

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

Has any member of your family been treated in this office? Yes No **Name** _____

Confidential Responsible Party Information

Email _____ **Marital Status** Single Married Divorced Widow/Widower

Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Own Rent **Cell/Home Phone** _____ **Work Phone** _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ **Birthdate** _____ **Relationship to Patient** _____

Employer _____ **Occupation** _____ **No. Years Employed** _____

Spouse's Name _____ **Relationship to Patient** _____
Last First Middle

Social Security # _____ **Birthdate** _____ **Cell Phone** _____

Employer _____ **Occupation** _____ **No. Years Employed** _____

Confidential Dental Insurance Information

Insured's Name #1 _____	Insured's Name #2 _____
Soc. Sec. # of Insured _____	Soc. Sec. # of Insured _____
Birthdate of Insured _____ / _____ / _____	Birthdate of Insured _____ / _____ / _____
Employer _____	Employer _____
Insurance Company _____	Insurance Company _____
Insurance Company Phone # (_____) _____	Insurance Company Phone # (_____) _____
Insurance Company Address _____	Insurance Company Address _____
_____	_____
Insurance Group # _____	Insurance Group # _____

I hereby authorize release of any information to other health care providers, insurance companies and business associates including personal health information, as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment of insurance benefits directly to Gray and Ehrler Orthodontic Specialists.

I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations. (A complete version of our HIPAA can be viewed on our website.)

I certify that the information on this form is complete and true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ **Today's date:** _____

Updated _____



Gray & Ehrler Orthodontic Specialists

Stewart Plaza • 436 N. Mountain Ave. • Upland, CA 91786
(909) 981-2025 • www.grayandehrlersortho.com

Comprehensive, personalized care for healthy, confident smiles

Does the patient:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have any health problems (current or past) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Take any medications (current or past) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | See a physician (current or past) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have allergies or sensitivity to medications or anything _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a history of any illnesses or hospitalizations _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a history of any surgery or major medical problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear contact lenses or an artificial aid _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Use drugs, alcohol, or tobacco _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth-breathing or have trouble breathing through the nose _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a tendency of ear infections or noises in the jaw joint _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any pain or clicking in the jaw joint or head/neck region _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Experience frequent headaches, or head/neck region _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Play any wind/reed instruments or the violin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have negative reactions or experiences to any type of dental work _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Need to take medication before dental work due to a heart or valve condition _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Snore or stop breathing at night. Do you have Apnea _____ |

Has the patient ever had any of the following:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble, congenital heart lesions | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or a family history of same |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur, heart pacer | <input type="checkbox"/> | <input type="checkbox"/> | Excessive chronic thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorders or family history |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever, heart valve problems | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis or stroke | <input type="checkbox"/> | <input type="checkbox"/> | Anemia, blood diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains on mild exertion | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorders, prolonged bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath during mild exertion | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, sore or swollen joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease or problems | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis, chronic or frequent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessively swollen ankles or tissues | <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis or other viral diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia, Bulimia | <input type="checkbox"/> | <input type="checkbox"/> | HIV virus or AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers, internal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema, breathing problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, respiratory problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, jaundice, liver problems | <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment, chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing problems, ringing in the ears | <input type="checkbox"/> | <input type="checkbox"/> | Malignancies, tumors or growths |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sores, herpetic lesions, canker sores | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rash, lesions, hives, fever blisters | <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity, nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate disorders | <input type="checkbox"/> | <input type="checkbox"/> | Fainting, dizziness, unconsciousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma, cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Chronic exhaustion or fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden weight change | <input type="checkbox"/> | <input type="checkbox"/> | Chronic nervousness, high stress |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma to face, chin, or jaw | <input type="checkbox"/> | <input type="checkbox"/> | Chronic unhappiness or depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent chronic headaches | <input type="checkbox"/> | <input type="checkbox"/> | Emotional problems or tension |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion, if so when | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment |

For female patients, is the patient now:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant | <input type="checkbox"/> | <input type="checkbox"/> | Taking or ever taken Bisphosphonates |
| <input type="checkbox"/> | <input type="checkbox"/> | Taking birth control | <input type="checkbox"/> | <input type="checkbox"/> | Diagnosed with Osteoporosis |

Please explain fully any "Yes" answers above, or any family history of any of the above conditions.

Please explain your orthodontic concerns and what you would like orthodontics to accomplish for you.

Confidential Emergency Information

Name of nearest relative not living with you _____
 Complete Address _____
 Phone _____ Relationship _____

I certify that the information above is true and accurate and that if there are any changes in this medical history, that I will notify this office. I agree to allow the orthodontist to discuss or share this information with whomever he/she deems necessary.

Patient/Legal guardian signature _____ Date _____