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

Confidential Patient Information

Patient's Name _____ (Last / First / Middle) ☐ **Male** ☐ **Female**

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 _____ (Last / First / Middle) Relationship to Patient _____

Social Security # _____ Birthdate _____ Cell Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Confidential Dental Insurance Information

Insured's Name #1 _____

Soc. Sec. # of Insured _____

Birthdate of Insured ____/____/____

Employer _____

Insurance Company _____

Insurance Company Phone # (_____) _____

Insurance Company Address _____

_____

Insurance Group # _____

Insured's Name #2 _____

Soc. Sec. # of Insured _____

Birthdate of Insured ____/____/____

Employer _____

Insurance Company _____

Insurance Company Phone # (_____) _____

Insurance Company Address _____

_____

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.grayandehrlerortho.com

Comprehensive, personalized care for healthy, confident smiles

Physician _____ **Dentist** _____ **Patient** _____

Does the patient:

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

Has the patient ever had any of the following:

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

For female patients, is the patient now:

Yes	No		Yes	No	
☐	☐	Pregnant	☐	☐	Taking or ever taken Bisphosphonates
☐	☐	Taking birth control	☐	☐	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 _____