GIBBS ORTHODONTIC ASSOCIATES, P.C.
PRACTICE LIMITED TO ORTHODONTICS

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Welcome to our office. Please complete this form so that we can provide the best orthodontic care for you.

GENERAL INFORMATION

Today's Date _____/_____/_____

Patient's Full Name _____ Home Telephone ( ) _____

Email Address _____

Address _____ Zip Code _____

Employed By _____ Bus. Telephone ( ) _____

Business Address _____ Zip Code _____

Names and Addresses of person or persons responsible for your account _____

_____ Zip Code _____

Name and Address of Insurance Company _____

_____ Zip Code _____

Whom May We Thank For Referring You To Us? _____

PATIENT HISTORY

Age _____ Date of Birth _____/_____/_____ M / F

Date of last Dental Check-up _____

Dentist's Name and Address _____ Zip Code _____

_____ Dentist's Telephone ( ) _____

List any Sports or Hobbies _____

List any Musical Instruments Played _____

MEDICAL HISTORY

Date of last Physical Examination _____

Physician's Name _____ Telephone ( ) _____

Address _____ Zip Code _____

General Health _____

Are you under the care of a physician at the present time and if so, for what? _____

_____

Are you taking any medications and if so, for what? _____

Are you ALLERGIC to any medicine, food or substance? _____

Are you subject to prolonged bleeding? _____

Have you ever been hospitalized? _____

Please check any of the following if you have or have had:

Anemia _____	Asthma _____	Respiratory/Lung Disorder _____
Diabetes _____	Dizziness _____	Blood Disorders _____
Brain Injury _____	Cerebral Palsy _____	Congenital Heart Disease _____
Fainting _____	Thyroid Disorders _____	Ear Problems/Infections _____
Digestive Disorders _____	Hepatitis _____	Visual Disorders _____
Epilepsy _____	Heart Murmur _____	Convulsions/Seizures _____
Renal/Kidney Disorders _____	Measles _____	Mononucleosis _____
Mumps _____	Hives/Skin Disorders _____	Hyperactivity _____
Learning Disabilities _____	Liver Disorders _____	Coordination Disorders _____
Jaundice _____	Ulcers _____	Heart Disorders _____
Sinus Disorders _____	Rheumatic Fever _____	Rheumatoid Arthritis _____
Sickle Cell Disease _____	Transfusions _____	Tuberculosis _____
Muscle Disorders _____	Speech Problems _____	Prostheses _____
	Other _____	

Please describe the items you have checked above _____

_____

Have you had any diseases not mentioned above _____

DENTAL HISTORY

What is the chief complaint about your teeth? _____

_____

Do you have any facial pain, clicking in the jaws, or temporomandibular joint pain? _____

Do you have any difficulties in chewing? _____

Have you ever sucked a finger, thumb, tongue, cheek, or pacifier? _____

Are you a tooth-grinder? _____

Have there been any injuries to the teeth, mouth or jaws? _____

Do you ever bite the upper or lower lip? _____

Are you a mouth breather? _____

Have you ever been informed of any missing or extra teeth? _____

Do you have frequent canker or cold sores? _____

Have you had a previous orthodontic examination? _____

Are the records available? _____

I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I understand that if any changes occur in my health, I am to report this to the office as soon as possible. Permission for necessary consultation with my dentist and/or physician is hereby granted. I have read and understand each question, and have answered all of them truthfully and to the best of my ability. I have discussed my health history with the doctor. Furthermore, the undersigned will be responsible for any fees incurred for the dental treatment rendered.

Patient's Signature _____ Date _____/_____/_____