

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First (Preferred)

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: M \_\_\_ F \_\_\_ Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

### Responsible Party Information

**PRIMARY INSURANCE INFORMATION:**

Insured parties Name: \_\_\_\_\_  
Last First (Preferred)

Relationship to Patient: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Receive Billing Statement? Y N

**WHO IS FINANCIALLY RESPONSIBLE FOR ACCOUNT?** Self \_\_\_\_\_, Other \_\_\_\_\_

Address (if different): \_\_\_\_\_  
Street City State Zip Code

\*\*\*\*If there is any additional information pertaining to billing, family status, relationship to patient, etc. that you think our office should be aware of, please let our receptionist know so she can add them to your family file.\*\*\*\*

### Health Information

Have you ever had any of the following? Please check all that apply:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> <b>PRE-MED REQUIRED</b>
<input type="checkbox"/> Allergies: _____	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <b>BISPHOSPHATE MEDICATIONS</b>
<input type="checkbox"/> Allergies to Medication: _____	<input type="checkbox"/> Cancer	<input type="checkbox"/> Respiratory Problems	<b>PLEASE INITIAL IF NONE OF THE PRECEDING CONDITIONS APPLY</b>
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Rheumatism	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Behavioral Disorder(s) Please specify: _____	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tumors	
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> High Blood Pressure	_____	
	<input type="checkbox"/> Mental Disorders		

\*\*\*\* Please list any medication you are currently taking: \_\_\_\_\_

Who is your (the patient's) general dentist? \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

#### Benefits of Orthodontics

Benefits of orthodontics include aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. If a good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

By signing below, I am stating that I have read and fully understand the above. I also recognize that my diagnostic records and my name may be used for educational and promotional purposes. I truthfully answered all of the above questions to the best of my knowledge and agree to inform this office of any changes in my medical, dental, or family history. In addition, I hereby authorize Dr. Jay R. Galati to perform a complete orthodontic evaluation.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_