Dr. Gulland Orthodontist

www.DrGulland.com

Adult (19 yrs and older)

WELCOME

My goal is to provide you with the best possible orthodontic experience. I consider it a privilege to work with you and I give you my word that I and my entire staff will do the very best for you. Please take a few moments to complete this form and bring it to your first visit.

Thank you,
Charles E. Gulland, D.M.D.

TELL US ABOUT YOU

Today's Date:_____

Name:_____
First Middle Last

I prefer to be called:_____

I am: ☐ Male ☐ Female Age:_____

Birthdate:_____ SS#:_____

Home Address:_____

_____

How long have you lived at this address?_____

Marital Status: ☐ Single ☐ Widowed ☐ Married
☐ Divorced ☐ Separated

Home Phone:_____

Cell Phone:_____

Work Phone:_____ Ext:_____

Email Address:_____

Best telephone number to call during business hours?

_____

Employer:_____

Employer's Address:_____

How long there?_____ Occupation:_____

Whom may we thank for telling you about us?_____

_____

Other family members seen by Dr. Gulland?_____

_____

General dentist:_____

Last visit date:_____ ☐ X-rays taken?

SPOUSE INFORMATION

His/Her name:_____

Employer:_____

Work Phone:_____ Ext:_____

Birthdate:_____ SS#:_____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's name: _____

Phone #:_____ Date of last visit _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking prescription/over the counter drugs? ☐ Yes ☐ No

Please list each one and the reason on reverse:

Do you smoke or use tobacco of any form? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:_____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems? Check Y or N.

Abnormal bleeding	Y N	Heart surgery/pacemaker	Y N
Anemia	Y N	Hemophilia	Y N
Artificial bones/joints/valves	Y N	Hepatitis	Y N
Asthma	Y N	Arthritis	Y N
High/low blood pressure	Y N	Blood transfusion	Y N
HIV+/Aids	Y N	Cancer/Chemotherapy	Y N
Hospitalized for any reason	Y N	Congenital heart defect	Y N
Kidney problems	Y N	Diabetes	Y N
Tuberculosis	Y N	Mitral valve prolapse	Y N
Difficulty Breathing	Y N	Psychiatric problems	Y N
Drug/Alcohol abuse	Y N	Rheumatic fever	Y N
Emphysema	Y N	Glaucoma	Y N
Severe/Frequent headaches	Y N	Epilepsy/seizures/fainting	Y N
Shingles	Y N	Fever blisters/herpes	Y N
Sinus Problems	Y N	Heart attack/stroke	Y N
Ulcers/colitis	Y N	Heart murmur	Y N
Venereal disease	Y N	Radiation treatment	Y N

Please list any serious medical condition(s) you have ever had:

_____

Have you or do you currently take Bisphonshonates?
(ie. Fosamax) ☐ Yes ☐ No

Are you allergic to any of the following?

Aspirin	Y N	Dental anesthetics	Y N	Penicillin	Y N
Any metals/plastics	Y N	Erythromycin	Y N	Tetracycline	Y N
Codeine	Y N	Latex	Y N	Other	Y N
Nickle	Y N				

Please list any other drugs/materials you are allergic to:

_____

_____

Continued on back

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC an the ADA.

DENTAL HISTORY

Do you like your smile? ☐ Yes ☐ No

What are the main concerns that you/they would like orthodontics to address? _____

_____

Have you ever been evaluated for orthodontic treatment? ☐ Y ☐ N

By whom?_____ When? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you require antibiotics before dental work? ☐ Yes ☐ No

Have you ever been told you have gingivitis or gum disease? ☐ Yes ☐ No

Have you ever seen a periodontist (gum specialist)? ☐ Yes ☐ No

How many times daily do you brush? _____

Do you floss your teeth daily? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Is your water fluoridated? ☐ Yes ☐ No

Do you have or have you ever had any of the following habits?

☐ Lip sucking/biting ☐ Speech problems ☐ Mouth breather

☐ Thumb/finger sucking ☐ Nail biting ☐ Tongue thrust

☐ Clench/grind teeth

Do you generally breath through your mouth? ☐ Yes ☐ No

If yes: ☐ While awake ☐ While asleep

Have your adenoids or tonsils been removed? ☐ Yes ☐ No

Do you have any speech problems? _____

Do you have any missing or extra permanent teeth? ☐ Unsure ☐ Yes ☐ No

Do you still have any wisdom teeth? ☐ Unsure ☐ Yes ☐ No

Have you ever had an injury to your? ☐ Mouth ☐ Teeth ☐ Chin

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

ALTERNATE CONTACT INFO

Please list someone not living with you to be used as an alternate contact should we need to contact you on short notice.

His/Her name:_____

Relation:_____

Work phone:_____

Home phone:_____

ADDITIONAL INFORMATION

Any additional information you can give us would be appreciated as the more we know about each other, the better we can help manage your treatment both at home and in the office.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent named herein.

Staff initials:_____ Date:_____

Doctor's comments: _____

_____

_____

_____

_____

_____

_____

List of Medications and Reason Taken:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for filling out this form completely

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services they may need. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

Signature of Patient Date