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:

____

____

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