RANDY L. GITTESS
D.D.S., P.A.
Practice Limited to Orthodontics

PATIENT INFORMATION

Thank you for taking a moment to complete this form.
This information is needed in order to provide
you with the best possible treatment.
All patient information remains confidential.

Date: _____ / _____ / _____

Name _____ Age _____
LAST FIRST MIDDLE

Address _____ Phone _____
STREET CITY STATE ZIP

Alternate Phone _____ E-mail _____ Birthdate _____ / _____ / _____

How long at present address? _____ Social Security # _____

School/Occupation _____ Grade _____

Who may we thank for referring you to our office? _____

Describe your orthodontic/TMJ concerns: _____

FAMILY INFORMATION

Father's (or husband's) Name _____ Social Security # _____

Employed by _____ How long _____ Occupation _____

Mailing Address _____ Phone _____

Mother's (or wife's) Name _____ Social Security # _____

Employed by _____ How long _____ Occupation _____

Mailing Address _____ Phone _____

FINANCIAL INFORMATION

Do you have orthodontic insurance? ☐ Yes ☐ No If yes, please complete the following:

1st Coverage: _____ _____
Employee Name | Employee SS# | Employee Birth Date

_____ _____
Employer | Insurance Company | Policy/Group Number

_____ _____
Employee Address *(if different from patient)* | Phone *(if different from patient)*

2nd Coverage: _____ _____
Employee Name | Employee SS# | Employee Birth Date

_____ _____
Employer | Insurance Company | Policy/Group Number

_____ _____
Employee Address *(if different from patient)* | Phone *(if different from patient)*

(Please continue on back)

MEDICAL HISTORY *(Please check Yes or No. If Yes, please fill in details.)*

Physician _____ Phone _____

☐ Yes ☐ No Are you allergic to any medications, latex or metal? _____

☐ Yes ☐ No Are you currently taking any medication? _____

☐ Yes ☐ No Do you have a history of major illness? _____

☐ Yes ☐ No Have you had any operations or accidents? _____

Please check any of the medical conditions below that you have had or currency have:

☐ AIDS	☐ Anemia	☐ Arthritis	☐ Asthma or Hay Fever	☐ Bone Disorders	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Gastrointestinal Disorders	☐ Heart Problems	☐ Hepatitis	☐ Herpes
☐ High Blood Pressure	☐ Kidney Involvement	☐ Liver Involvement	☐ Nervous Disorders	☐ Pneumonia	
☐ Prolonged Bleeding	☐ Rheumatic Fever	☐ Tuberculosis	☐ Tumor or Cancer		

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Relationship _____

Address _____ Phone _____

DENTAL HISTORY *(Please check Yes or No. If Yes, please fill in details.)*

Dentist _____ Phone _____

What concerns you most about your teeth?

☐ Yes ☐ No Are you presently in any dental pain? _____

☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry? _____

☐ Yes ☐ No Have you ever lost or chipped any teeth? _____

☐ Yes ☐ No Have there ever been any injuries to face, mouth or teeth? _____

☐ Yes ☐ No Do your gums bleed when you brush? _____

☐ Yes ☐ No Do you have any pain or soreness around your face, neck or back? _____

☐ Yes ☐ No Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____

☐ Yes ☐ No Are you aware of your jaw clicking or popping? _____

☐ Yes ☐ No Have you ever been told you grind your teeth? _____

☐ Yes ☐ No Do you have “tension” headaches, ear, eye or sinus problems? _____

☐ Yes ☐ No Are you aware that some appointments will be during school/work hours? _____

BENEFITS OF ORTHODONTICS - Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the 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 good oral hygiene is not practiced, tooth deny and enlarged gums can result. Temporomandibular Joint (TMJ) discomfort and root shortening are observed in a small percentage of cases.

I hereby state that I have read and understand the above paragraph and that I have truthfully, to the best of my ability, answered all the above questions.

Patient/Parent _____ Date _____

Dr. Randy L. Gittess _____ Date _____