



WELCOME TO OUR OFFICE!

How did you find out about us? _____

Who Are We Seeing Today:

Patient's Full Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Secondary Number: _____

*Email: _____ Social Security: _____

Patient's School Name: _____

Who is your Dentist? _____ Dentist Phone #: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Would you like to get braces *today*? _____

RESPONSIBLE PARTY INFORMATION MUST BE FILLED OUT

Full Name: _____ Date of Birth: _____

Phone #: _____ Secondary Phone # _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ *Social Security #: _____

Insurance Information

Insurance Company: _____ Employed by: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's ID#: _____ Group Number: _____

Secondary Insurance Information (If applicable)

Insurance Company: _____ Employed by: _____
Policy Holder's Name: _____ Policy Holder's Date of Birth: _____
Policy Holder's ID#: _____ Group Number: _____

Please Circle Yes or No to the Following Questions:

Have you seen a dentist in the last six months? YES NO

Any cavities or gum problems that need treatment or have been treated? YES NO

If so, please explain: _____

Any injuries to the teeth, jaws, or head? YES NO

If so, please explain: _____

Circle any of the following habits the patient may have:

Glenching / Grinding Teeth, Mouth Breathing, Nail Biting, Speech Problems, Chews on Ice / Pens / Pencils

None of the above

Seeing a physician? YES NO

Are there any medical, psychiatric, physical, or other health conditions that required past or ongoing medical doctor visits and/or treatment? YES NO

If so, please explain: _____

Do you take any prescription or over-the-counter medications? YES NO

If so, please explain: _____

Do you have any allergies? YES NO

If so, please explain: _____

Are you pregnant or is there a chance you are pregnant? YES NO

Confirmation

I understand that the information I have provided about the patient and or/myself is correct to the best of my knowledge and that it is my responsibility to inform the office of any changes in medical status that occur after this date. I authorize Braces By Garcia to perform an initial orthodontic examination and any necessary dental services that I or the patient may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____

Thank you for filling out this form completely!