

Confidential Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____ City _____ State _____ Zip _____

Home Phone _____

Age _____ Birthdate _____ M _____ F _____ SS# _____

If patient is a minor, give custodial parent's or legal guardian's name _____

Name of General Dentist _____ Date of Last Visit _____ Cleaning Yes No
X-Rays Yes No

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

School _____ E-mail Address _____

Any members of family treated in this office? Yes No Names: _____

Confidential Responsible Party Information

Name _____
Last First Middle **Marital Status** _____

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

How long at this address _____ Own Rent

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

E-mail Address _____

Confidential Dental Insurance Information

Insured's Name _____ Soc. Sec. # / ID # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____

Type of Insurance Coverage: Dental Orthodontic Do you have dual coverage? Yes No If Yes, complete following:

Insured's Name _____ Soc. Sec. # / ID # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

I authorize release of information regarding my insurance benefits. _____ **(Insured Signature)**

Confidential Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

The orthodontic office of Joseph Gray, DDS, MS • Todd Ehrler, DDS, MS complies with the HIPPA Privacy Act of 2003



Gray & Ehrler Orthodontic Specialists

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A Team Committed to Excellence and Satisfaction

Does the patient:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have any health problems (current or past) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Take any medications (current or past) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | See a physician (current or past) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have allergies or sensitivity to medications or anything _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a history of any illnesses or hospitalizations _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a history of any surgery or major medical problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear contact lenses or an artificial aid _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Use drugs, alcohol, or tobacco _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth-breathing or have trouble breathing through the nose _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a tendency of ear infections or noises in the jaw, joint _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any pain or clicking in the jaw joint or head/neck region _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Experience frequent headaches, or head/neck region _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Play any wind/reed instruments or the violin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have negative reactions or experiences to any type of dental work _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Need to take medication before dental work due to a heart or valve condition _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Snore or stop breathing at night? Do you have Apnea? _____ |

Has the patient ever had any of the following:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble, congenital heart lesions | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or a family history of same |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur, heart pacer | <input type="checkbox"/> | <input type="checkbox"/> | Excessive chronic thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorders or family history |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever, heart valve problems | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis or stroke | <input type="checkbox"/> | <input type="checkbox"/> | Anemia, blood diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains on mild exertion | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorders, prolonged bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath during mild exertion | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, sore or swollen joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease or problems | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis, chronic or frequent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessively swollen ankles or tissues | <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis or other viral diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia, Bulimia | <input type="checkbox"/> | <input type="checkbox"/> | HIV virus or AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers, internal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema, breathing problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, respiratory problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, jaundice, liver problems | <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment, chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing problems, ringing in the ears | <input type="checkbox"/> | <input type="checkbox"/> | Malignancies, tumors or growths |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sores, herpetic lesions, canker | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rash, lesions, hives, fever blisters | <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity, nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate disorders | <input type="checkbox"/> | <input type="checkbox"/> | Fainting, dizziness, unconsciousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma, cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Chronic exhaustion or fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden-weight change | <input type="checkbox"/> | <input type="checkbox"/> | Chronic nervousness, high stress |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma to face, chin, or jaw | <input type="checkbox"/> | <input type="checkbox"/> | Chronic unhappiness or depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent chronic headaches | <input type="checkbox"/> | <input type="checkbox"/> | Emotional problems or tension |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion, if so when _____ | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment |

For female patients, is the patient now:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant | <input type="checkbox"/> | <input type="checkbox"/> | Presently in menopause |
| <input type="checkbox"/> | <input type="checkbox"/> | Taking birth control | <input type="checkbox"/> | <input type="checkbox"/> | Past menopause |

Please explain fully any "Yes" answers above, or any family history of any of the above conditions.

Please explain your orthodontic concerns and what you would like orthodontics to accomplish for you.

I certify that the information above is true and accurate and that if there are any changes in this medical history, that I will notify this office. I agree to allow the orthodontist to discuss or share this information with whomever he/she deems necessary.

Patient/Legal guardian signature _____ Date _____