



Garry G. Gast, D.D.S.
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Patient Number

Date

PATIENT INFORMATION

Name: _____ Birthdate: _____ Age: _____ Sex: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ If Student, School Name: _____
 Sports or Hobbies: _____

COMPLETE FOR ADOLESCENT PATIENT

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN INFORMATION

Name

Address

City State Zip

Home Phone Work Phone

Name

Address

City State Zip

Home Phone Work Phone

Responsible Party

Billing Address

INSURANCE INFORMATION

SELF/PARENT/GUARDIAN

SPOUSE/PARENT/GUARDIAN

Employer Name

Employer Address

Employer City State Zip

Number of Years Employed Occupation

Birthdate Age Sex Marital Status

Employer Name

Employer Address

Employer City State Zip

Number of Years Employed Occupation

Birthdate Age Sex Marital Status

COMPLETE BELOW IF YOU HAVE DENTAL COVERAGE

Check here if coverage includes orthodontic benefits

Subscriber Name

Subscriber #

Insurance Company Name

Insurance Address

Insurance City State Zip

Insurance Phone Ext.

Group # Local or Union #

Subscriber Name

Subscriber #

Insurance Company Name

Insurance Address

Insurance City State Zip

Insurance Phone Ext.

Group # Local or Union #

OTHER INFORMATION

Dentist Name

Physician Name

Who may we thank for referring you?

Other Children Birthdate

Other Children Birthdate

Other Children Birthdate

Please Complete Backside

MEDICAL INFORMATION

Any Heart Disease:	YES NO	Rheumatic/Yellow/Scarlet Fever:	YES NO	Heart Murmur:	YES NO	Asthma or Hay Fever:	YES NO
Any Respiratory Disease:		Acquired Immune Deficiency Syndrome:		Mononucleosis:		Tuberculosis:	
Any Blood Disease:		Is the Patient Under Medical Care:		Hepatitis:		Any Broken Bones:	
Any Liver Disease:		Rheumatism or Arthritis:		Polio:		Prolonged Bleeding:	
Any Thyroid Disease:		Is the Patient taking any Medications:		Diabetes:		Yellow Jaundice:	
Any Kidney Disease:		A History of Fainting or Dizziness:		Anemia:		Radiation Therapy:	
H.I.V. Positive:		Does the Patient have a Drug Addiction:		Hemophilia:		Chemical Therapy:	
Any Venereal Disease:		Is the Patient Pregnant at this Time:		Emphysema:		Blood Transfusions:	
Any Intestinal Disease:		Measles/Mumps/Chicken Pox:		Epilepsy:		Latex Allergy:	
Any Bone Disease:		Does the Patient Smoke:		Is the Patient Allergic to Anything:			
Any Nervous/Emotional Problems:		Has the Patient ever had Fever Blisters:		What: _____			
Any High or Low Blood Pressure:		Is Height & Weight Normal for Age:		List any Medications: _____			
Any Endocrine Problems:		Is the Patient in Good Health:		Are you aware of any other disease, condition, or problem not listed above that we should know about:			
Any Problems with Wounds Healing:		Has the Patient had a Physical this Year:		If Yes, What: _____			
Any Tumors or Cancer:		Has the Patient Reached Puberty:					

DENTAL HISTORY

Has the Patient Seen a General Dentist in the Last Year:	YES NO	Does the Patient Have or Ever Had Any of the Following Habits:	
Any Pain, Clicking or Discomfort In or Near the Ears:		Cheek, Tongue or Lip Chewing:	YES NO
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		Thumb Sucking:	
Have You Been Informed of Missing or Extra Permanent Teeth:		Mouth Breathing:	
Are You Aware of Any "Gum" Problems:		Finger Nail Biting:	
Have the Patient's Tonsils or Adenoids Been Removed:		Clenching Teeth:	
Would the Patient Mind Wearing "Braces":		Tongue Thrusting:	
		Grind Teeth:	
		Speech Problems:	
		Has the Patient Been Examined by an Orthodontist Before:	
		If Yes, When: _____	
		Have Other Members of the Family had Orthodontic Treatment:	
		If Yes, Were You Happy With the Results: _____	
		If No, Why: _____	
In Your Own Words What is the Orthodontic Problem: _____			
What Would you Like Orthodontic Treatment to Accomplish: _____			

FOR OFFICE USE ONLY

X-Rays: Lab	X-Rays: Dentist	Date:	Procedure:	Appt.:
Problem:				
Tentative TX:				