GADSDEN ORTHODONTICS

NEW PATIENT INFO

256.399.0799
Info@GadsdenOrthodontist.com
315 S.4th Street
Gadsden, Al 35901

DATE: _____

LAST NAME _____ FIRST NAME _____ NICKNAME _____ GENDER _____

SSN _____ BIRTHDATE _____ AGE _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL # _____ CARRIER _____ HOME # _____ WORK # _____

(IF APPLICABLE)

SCHOOL _____ GRADE ____

[ ] SINGLE [ ] MARRIED

[ ]DIVORCED [ ] WIDOWED

OCCUPATION _____

EMPLOYER _____

NAME OF DENTIST _____ DATE OF LAST VISIT _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

ANY OTHER CHILDREN IN THE HOUSE? (PLEASE LIST WITH AGE)

_____

PARENTAL INFORMATION

Please complete if patient is a minor. Check box for responsible party.

☐ FATHER'S NAME _____ SSN _____ DATE OF BIRTH _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
CELL # _____ CARRIER _____ HOME # _____ WORK # _____
OCCUPATION/EMPLOYER _____ EMAIL _____

☐ MOTHER'S NAME _____ SSN _____ EMAIL _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
CELL # _____ CARRIER _____ HOME # _____
WORK # _____ OCCUPATION/EMPLOYER _____

☐ GUARDIAN'S NAME _____ SSN _____ EMAIL _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
CELL # _____ CARRIER _____ HOME # _____
WORK # _____ OCCUPATION/EMPLOYER _____

INSURANCE INFORMATION

NAME _____ GROUP MEMBER BIRTHDATE_____ RELATION TO PATIENT _____

INSURANCE COMPANY _____ CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE (IF APPLICABLE)

NAME_____ GROUP MEMBER BIRTHDATE_____ RELATION TO PATIENT_____

INSURANCE COMPANY _____ CONTRACT # _____ GROUP #_____

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE

GADSDEN ORTHODONTICS

NEW PATIENT HISTORY

256.399.0799
Info@GadsdenOrthodontist.com
315 4th Street
Gadsden, Al 35901

MEDICAL HISTORY

Please check if patient has or has had the following:

- O Joint swelling
- O Bone disorders
- O Heart trouble
- O Mitral valve prolapse
- O Rheumatic trouble
- O Diabetes
- O Emotional problems
- O Brain injury
- O Kidney or liver involvement
- O Joint prosthesis
- O Tuberculosis
- O Anemia
- O Epilepsy (convulsions)
- O Prolonged bleeding
- O Faintness/dizziness
- O Tonsils removed
- O Adenoids removed
- O Sore throat
- O Tonsillitis
- O Earaches
- O Arthritis
- O Latex allergy
- O Thyroid problems

Have you ever or any members of your family had:
[Y] [N] Rheumatoid Arthritis
[Y] [N] Lupus

On items checked, please provide a more detailed description:

_____

_____

_____

Name of Primary Physician: _____Is the patient currently under a physician's care for any reason? [Y] [N]

If yes, please explain: _____

List any other serious illnesses: _____

If patient has begun menstruation what date? Month/Year: _____

Approx. how much has the patient grown in the last year? _____

List drugs or medications currently taking:_____

Taking any Osteoporosis Medications: Y N If yes, please list:_____

List of allergies: _____

DENTAL HISTORY

Please check if patient has or has had the following:

- O Any injuries to face, mouth or teeth?
- O Thumb, finger, or lip sucking
- O More than average amount of tooth decay
- O Extra permanent teeth
- O Teeth removed by extraction
- O Difficulty in swallowing or chewing
- O Any pain or clicking when opening mouth
- O Is the patient adopted? At what age? ___
- O Previously consulted with another orthodontist

Does the patient visit the dentist regularly? O Y O N

On items checked, please provide a more detailed description:

_____

_____

Signature: _____ *Date:*_____

GADSDEN
ORTHODONTICS

PRIVACY CONSENT

256.399.0799
info@gadsdenorthodontist.com
315 S. 4th Street
Gadsden, Al 35901

Your protected health information may need to be used in connection with your treatment, payment of your account, or health care operations. Please check all boxes you consent to.

- ○ Patient treatment notes used in discussion with other Doctors' offices for treatment purposes.
- ○ Patient X-rays and pictures emailed, faxed or mailed to other Doctors' offices for treatment purposes.
- ○ Patient pictures posted to Social Media sites such as Facebook to celebrate removal of appliances, etc.
- ○ Patient pictures and treatment information used by the Doctor for educational purposes.

You have the right to review this Privacy Consent at any time.

Responsible Party: _____ Relationship: _____

Signature: _____ Date: _____

Patient Name: _____

GADSDEN
ORTHODONTICS

Orthodontic Information Release Form

Patient Name_____ **Date of Birth**_____

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, treatment, and examination information. This information may be released to:

( ) Spouse _____
( ) Parent/Guardian_____
( ) Dentist_____
( ) Other_____
( ) Information is not to be released to anyone.

I authorize the release of financial information to the following people:

( ) Spouse_____
( ) Parent/Guardian _____
( ) Other _____

APPOINTMENTS

I authorize the following people to bring my child to appointments:

_____

_____

_____

This release will stay in effect until treatment is completed or a release cancellation is obtained.

_____ _____

Parent or Guardian Date