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

LAST NAME FIRST NAME NICKNAME GENDER  SSN BIRTHDATE AGE EMAIL  ADDRESS CITY STATE ZIP  CHOOL GRAPEL [] MARRIED [] DINVORCED [] WIDDOWED  OCCUPATION  EMPLOYER  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  OCCUPATIONVEMPLOYER EMAIL  MOTHER'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  OCCUPATIONVEMPLOYER EMAIL  MOTHER'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  CELL # CARRIER HOME # WORK #  OCCUPATIONVEMPLOYER  GUARDIAN'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  CELL # CARRIER HOME #  WORK # OCCUPATIONVEMPLOYER  GUARDIAN'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  CELL # CARRIER HOME #  WORK # OCCUPATIONVEMPLOYER  GUARDIAN'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  CELL # CARRIER HOME #  WORK # OCCUPATIONVEMPLOYER  GUARDIAN'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  CARRIER HOME #  WORK # OCCUPATIONVEMPLOYER  GUARDIAN'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  CARRIER HOME #  WORK # OCCUPATIONVEMPLOYER  FINSURANCE INFORMATION  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT  INSURANCE COMPANY CONTRACT # GROUP #  INSURANCE COMPANY CONTRACT # GROUP #			D	ATE:				
SSN BIRTHDATE AGE EMAIL  ADDRESS CITY STATE ZIP  CELL# CARRIER HOME # WORK #   (IF APPLICABLE)  SCHOOL GRADE WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?  [ ] DIVORCED [ ] WIDOWED  OCCUPATION ANY OTHER CHILDREN IN THE HOUSE? (PLEASE LIST WITH AGE)  EMPLOYER	LAST	Г NAME	FIRST NAME	NI	CKNAME		GENDER	
ADDRESSCARRIER HOME #WORK #	SSN		BIRTHDATE	AGE	EMA	IL		
CELL # CARRIER HOME # WORK #  (IF APPLICABLE)  SCHOOLGRADE [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED  OCCUPATION  EMPLOYER  PARENTAL INFORMATION  Please complete if patient is a minor. Check box for responsible party.  FATHER'S NAMESSNDATE OF BIRTH ADDRESSCITYSTATEZIP  OCCUPATION/EMPLOYEREMAIL  MOTHER'S NAMESSNEMAIL  CELL #CARRIERHOME #  WORK #OCCUPATION/EMPLOYER  GUARDIAN'S NAMESSNEMAIL  ADDRESSCITYSTATEZIP  GUARDIAN'S NAMESSNEMAIL								
SCHOOL GRADE WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?  [ ] SINGLE [ ] MARRIED								
[] SINGLE [] MARRIED [] DIVORCED [] WIDOWED  ANY OTHER CHILDREN IN THE HOUSE? (PLEASE LIST WITH AGE)  PARENTAL INFORMATION  Please complete if patient is a minor. Check box for responsible party.  PATHER'S NAME SSN DATE OF BIRTH  ADDRESS CITY STATE ZIP  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 (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT  RELATION TO PATIENT  RELATION TO PATIENT	(IF AP	PPLICABLE)		NAME OF DENT	IST	D	ATE OF LAST VISIT	
ANY OTHER CHILDREN IN THE HOUSE? (PLEASE LIST WITH AGE)  EMPLOYER  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  OCCUPATION/EMPLOYER  EMAIL  MOTHER'S NAME  SSN  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 #  WORK #  OCCUPATION/EMPLOYER  INSURANCE INFORMATION  NAME  GROUP MEMBER BIRTHDATE  RELATION TO PATIENT  INSURANCE (IF APPLICABLE)  NAME  GROUP MEMBER BIRTHDATE  RELATION TO PATIENT	Management of the second secon			WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				
PARENTAL INFORMATION  Please complete if patient is a minor. Check box for responsible party.  FATHER'S NAME SSN DATE OF BIRTH ZIP  ADDRESS CITY STATE ZIP  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  FATHER'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  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT	OCCUPATION							
ADDRESSCITYSTATEZIP	FATHER'S NAME SSN DATE OF BIRTH							
CELL # CARRIER HOME # WORK #  OCCUPATION/EMPLOYER EMAIL  MOTHER'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  WORK # OCCUPATION/EMPLOYER  GUARDIAN'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  CELL # CARRIER HOME # ZIP  ADDRESS CITY STATE ZIP  CELL # CARRIER HOME # ZIP  WORK # OCCUPATION/EMPLOYER  INSURANCE INFORMATION  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT GROUP #		FATHER'S NAME		SSN	DA	ATE OF BIRT	H	
OCCUPATION/EMPLOYER EMAIL		CELL #	CARRIER	H	OME #		WORK #	
ADDRESSCITYSTATEZIP  CELL #CARRIER HOME #  WORK #OCCUPATION/EMPLOYER  GUARDIAN'S NAMESSNEMAIL  ADDRESSCITYSTATEZIP  CELL #CARRIER HOME #  WORK #OCCUPATION/EMPLOYER  INSURANCE INFORMATION  NAMEGROUP MEMBER BIRTHDATE RELATION TO PATIENT  INSURANCE COMPANYCONTRACT #GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAMEGROUP MEMBER BIRTHDATE RELATION TO PATIENT		OCCUPATION/EMPLO	OYER		EMAIL			
ADDRESSCITYSTATEZIP  CELL #CARRIER HOME #  WORK #OCCUPATION/EMPLOYER  GUARDIAN'S NAMESSNEMAIL  ADDRESSCITYSTATEZIP  CELL #CARRIER HOME #  WORK #OCCUPATION/EMPLOYER  INSURANCE INFORMATION  NAMEGROUP MEMBER BIRTHDATE RELATION TO PATIENT  INSURANCE COMPANYCONTRACT #GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAMEGROUP MEMBER BIRTHDATE RELATION TO PATIENT		MOTHER'S NAME		SSN	E	MAIL		
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		ADDRESS			STA	ATE	_ ZIP	
GUARDIAN'S NAME SSN EMAIL  ADDRESS CITY STATE ZIP  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  SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT	Ш	CELL #	CARRIER	H	OME #			
ADDRESSCITYSTATEZIP  CELL #CARRIERHOME #  WORK #OCCUPATION/EMPLOYER  INSURANCE INFORMATION  NAMEGROUP MEMBER BIRTHDATERELATION TO PATIENT  INSURANCE COMPANYCONTRACT #GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAMEGROUP MEMBER BIRTHDATERELATION TO PATIENT		WORK #	OCCUPATION/E	MPLOYER				
ADDRESSCITYSTATEZIP  CELL #CARRIERHOME #  WORK #OCCUPATION/EMPLOYER  INSURANCE INFORMATION  NAMEGROUP MEMBER BIRTHDATERELATION TO PATIENT  INSURANCE COMPANYCONTRACT #GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAMEGROUP MEMBER BIRTHDATERELATION TO PATIENT	-	GUARDIAN'S NAME _	==	SSN		EMAIL _		
NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT GROUP # GROUP MEMBER BIRTHDATE RELATION TO PATIENT GROUP # GROUP MEMBER BIRTHDATE RELATION TO PATIENT GROUP # GROUP MEMBER BIRTHDATE RELATION TO PATIENT GROUP MEMBER BIRTHDATE RELATION TO PATIENT		ADDRESS		_ CITY	ST/	ATE	_ ZIP	
INSURANCE INFORMATION  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT  INSURANCE COMPANY CONTRACT # GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT		CELL #	CARRIER	MDI OVED	OME #		and the same	
NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT  INSURANCE COMPANY CONTRACT # GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT		WORK #						
INSURANCE COMPANY CONTRACT # GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT			INSUF	rance info	RMATIC	ON		
INSURANCE COMPANY CONTRACT # GROUP #  SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT	NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT							
SECONDARY INSURANCE (IF APPLICABLE)  NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT	INSURANCE COMPANY GROUP # GROUP #							
NAME GROUP MEMBER BIRTHDATE RELATION TO PATIENT	SEC	ONDARY INSURANCE (	(IF APPLICABLE)					
CONTRACT # GROUP #	NAN	ΛΕ	GROUP MEM	IBER BIRTHDATE	REI	LATION TO	PATIENT	
INSURANCE COMPANY CONTRACT # GROOT " GROOT " **WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE**	INSU	JRANCE COMPANY	++\A/E NIEED TO \$44\/E A	CONTRACT	H	DRIVER'S LIC	GROUP #	



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:

0	Joint swelling	0	Epilepsy (convulsions	) [			
0	Bone disorders	0	Prolonged bleeding	Have you ever or any members of your family had:			
0			Faintness/dizziness	[Y] [N] Rheumatoid Arthritis			
0	Mitral valve prolapse	0	Tonsils removed	[Y] [N] Lupus			
0	Rheumatic trouble	0	Adenoids removed				
0	Diabetes	0	Sore throat	On items checked, please provide a more detailed			
0	Emotional problems	0	Tonsillitis	description:			
0	Brain injury	0	Earaches				
0	Kidney or liver involvement	0	Arthritis				
0	Joint prosthesis	0	Latex allergy				
0	Tuberculosis	0	Thyroid problems				
0	Anemia						
Name	e of Primary Physician:		Is the patient currently	under a physician's care for any reason? [Y] [N]			
	please explain:						
	ny other serious illnesses:						
	ient has begun menstruation who						
	ox. how much has the patient gro						
	List drugs or medications currently taking:						
Taking any Osteoporosis Medications: Y N If yes, please list:							
List o	f allergies:						
			DENTAL H	HISTORY ——			
	Plea	se ci	heck if patient has	or has had the following:			
0	Any injuries to face, mouth or to	eth?	0	Is the patient adopted? At what age?			
0	Thumb, finger, or lip sucking		0	Previously consulted with another orthodontist			
0	More than average amount of tooth decay		decay	Does the patient visit the dentist regularly? O Y O N			
0	Extra permanent teeth		Do				
0	Teeth removed by extraction			items checked, please provide a more detailed description:			
0	D Difficulty in swallowing or chewing						
O Any pain or clicking when opening mouth							
Cinn at use							
	Signature:						



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 treatmen	t,
payment of your account, or health care operations. Please check all boxes you consent	to.

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



## **Orthodontic Information Release Form**

Patient Name	Date of Birth
F	ELEASE OF INFORMATION
examination information. T  ( ) Spouse	information including the diagnosis, treatment, and his information may be released to:
( ) Parent/Guardia	n
( ) Other	not to be released to anyone.
()Spouse ()Parent/Guardia	financial information to the following people:
	APPOINTMENTS
I authorize the following	people to bring my child to appointments:
This release will stay in effection cancellation is obtained.	ect until treatment is completed or a release
Parent or Guardian	Date