GALES FERRY ORTHODONTICS, LLC
1527 Route 12, PO BOX 395, GALES FERRY, CT 06335
860-464-1370

Confidential Patient Information

Patient's Name ____ Sex: M F
Last First Middle

Address ____
Street City State Zip

Home Phone ____________________ Birthdate ____________________

If patient is a minor, with whom does the patient reside? ____________ Relationship ________

Who is the patient's dentist? ____________ When was their last visit? ____________

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

Please list any family members who have had treatment in our office ____________________

Please list any interests or hobbies ____________________

Confidential Responsible Party Information

Name ____ Marital status: S M D W
Last First Middle

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

How long at this address ________ Previous City/State (if less than 3 yrs.) ____________

Would you like to receive appointment reminders via email? Y N

If yes, please provide the primary email address for parent(s): ____________________

Home Phone __________ Work Phone __________ Cell Phone __________

Social Security # __________ Birthdate ________ Relationship to patient __________

Employer ______________ Occupation ______________ Years Employed ______

Spouse's Name ____________________ Relationship to patient ____________
Last First Middle

Employer ______________ Occupation ______________ Years Employed ______

Home Phone __________ Work Phone __________ Cell Phone __________

Dental/Orthodontic Insurance Information

Policy Holder's Name ____________________ SSN ____________

Policy Holder's Date of Birth ____________________ Member ID # ____________

Insurance Company ______________ Group # __________ Union local # ______

Insurance Co. Address ____________________ Insurance Co. Phone ____________

Policy Holder's Employer ____

Do you have dual coverage? N Y (*If yes, please complete below*)

Policy Holder's Name ____________________ SSN ____________

Policy Holder's Date of Birth ____________________ Member ID # ____________

Insurance Company ______________ Group # __________ Union local # ______

Insurance Co. Address ____________________ Insurance Co. Phone ____________

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

Signature (parent's signature if minor) ______________________________ **Date** ________

Confidential Medical and Dental History

Has the patient ever had any of the following medical problems?

Y N Abnormal bleeding
Y N Allergies to any drugs
Y N Allergies to latex
Y N Any hospital stays
Y N Any operations/surgeries
Y N Asthma
Y N Cancer
Y N Chronic sinus problems
Y N Congenital heart defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Endocrine/Growth Disorders
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia/Blood disorders
Y N Hepatitis
Y N HIV/AIDS
Y N Kidney/Liver problems
Y N Nickel allergy
Y N Rheumatic/Scarlet fever
Y N Tonsils/adenoids removed
Y N Tuberculosis
Other: ________________

Has the patient ever been told to take an antibiotic prior to dental visits? Y N
Is the patient currently under the care of a physician for any medical problems? Y N

Please discuss any *Yes* answers in the space provided: ____

____

Please describe the patient's current physical health: Good Fair Poor
When was the patient's last physical? ______________________ Patient's Physician _________________________
Please list any drugs/medications that the patient is taking: ____

Does the patient have any of the following habits?

Y N Clenching or grinding teeth
Y N Lip sucking or biting
Y N Mouth breathing
Y N Nail biting
Y N Smoking
Y N Nursing bottle habit
Y N Speech problems and/or speech therapy
Y N Thumb or finger sucking
Y N Tongue thrust
Other: ______________________________

What are the main concerns that you would like the orthodontic treatment to address? ______________________

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Has the patient ever been evaluated or had orthodontic treatment before? Y N
Has the patient ever received an injury to the face, mouth, teeth, or chin? Y N
Have you been informed about any missing or extra permanent teeth? Y N
Has the patient ever had any pain, tenderness, and/or clicking in the temporomandibular joint (TMJ)? Y N
Please discuss *Yes* answers to the above questions: ____

____

Does the patient have good oral hygiene habits?
Does the patient see a general dentist regularly for check-ups?
Please make any other comments that you feel might be helpful: ____

____

I understand the information I have provided is correct to the best of my knowledge and will be held in the strictest of confidence, and that it is my responsibility to inform the office of any changes in the patient's medical status.

Signature ____ **Date** ____________________

Emergency Information

Name of nearest relative/neighbor/friend not living with you ____

Complete Address ____

Phone ____ Relationship _______________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgment *

I have received a copy of this office's Notice of Privacy Practices.

Print Name ____

Signature ____

Date ____

--- **For Office Use Only** ---

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please Specify)

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