Garcia Family Orthodontics™
ANA V. GARCIA, DDS, MSD

ABOUT THE PATIENT

Today's Date: _____ Nickname: _____

Name: _____

LAST FIRST MIDDLE

Birthdate: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Social Security #: _____

Home Address: _____

_____

CITY STATE ZIP CODE

Email Address: _____

Home #: _____ Cell #: _____

Orthodontic Insurance

Orthodontic Coverage Y N

Insurance Co. Name:

_____

Insurance Co. Phone #:

_____

Policy Owner's Name:

_____

Birthdate: ____/____/____

SS#/ ID#: _____

Relation to patient:

_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

DOB: ____/____/_____ ☐ Male ☐ Female

SS#: _____ DL#: _____

Marital Status: ☐ Singe ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

☐ check if same as above

Address: _____

_____

CITY STATE ZIP CODE

Relation to Patient: _____

Home #: _____ Cell #: _____

Work #:_____ Number of years with current employer? _____

Employer: _____ Occupation: _____

What is the best method for us to contact you? Cell Home Work Email

SPOUSE INFORMATION

Name: _____ DOB: ____/____/____

SS#: _____ Cell #: _____

Employer: _____ Occupation: _____

Dental Information

General Dentist:

_____

Date of last cleaning/ visit:

_____

How did you hear about us? (Check all that apply)

☐ Dentist

☐ Family Member/ Friend

☐ Website

☐ Google

☐ Social Media

☐ School:

_____

☐ Other (Please Specify):

_____

Other family members seen by us:

_____

_____

Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Had or been evaluated for orthodontic treatment?	Y	N
Had a serious/difficult problem associated with any previous dental work?	Y	N
Had any injuries to the face, mouth, teeth or chin?	Y	N
When? Explain? _____		
Do you now, or have you experienced pain/discomfort in your jaw joint (TMJ/ TMD)?	Y	N
Do you like your smile?	Y	N
Gums ever bleed?	Y	N
Do you see a general dentist regularly?	Y	N
Have speech problems?	Y	N
Had tonsils or adenoids removed?	Y	N
Do you have any missing or extra permanent teeth?	Y	N
Do you brush your teeth daily?	Y	N
Floss daily?	Y	N
Ever taken Phen-Fen (Redux, Pondimin)?	Y	N
Ever taken Fosamax, or any other bisphosphonate?	Y	N
Are you aware that some appointments may/will infringe upon work or school time?	Y	N
Do you smoke or use tobacco in any form?	Y	N

ALLERGIES/ PRE-MED (CHECK ALL THAT APPLY)

☐ Aspirin ☐ Erythromycin ☐ Penicillin

☐ Codeine ☐ Nickel/ Metals ☐ Tetracycline

☐ Dental Anesthetics ☐ Latex ☐ Other: _____

Do you require pre-medication before any dental procedure? Y N

Have you ever experienced any of the following?

Clenching/ Grinding Teeth	Y	N
Nursing Bottle Habits	Y	N
Lip Sucking/ Biting	Y	N
Speech Problems	Y	N
Mouth Breather	Y	N
Thumb/ Finger Sucking	Y	N
Nail Biting	Y	N
Tongue Thrust	Y	N
Used Pacifier until age _____	Y	N

By signing below, patient/ responsible party acknowledges the information filled out on this form is accurate and agrees to notify Garcia Family Orthodontics/ Ana V. Garcia, DDS PA of any changes that occur. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature: _____ Date: _____

Medical History

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y	N
ADD/ ADHD	Y	N
Anemia	Y	N
Any hospital stays When? _____	Y	N
Any Operations When? What? _____	Y	N
Artificial Bones/Joints/Valves	Y	N
Arthritis	Y	N
Asthma	Y	N
Blood Transfusion	Y	N
Cancer/Chemotherapy	Y	N
Chicken Pox	Y	N
Congenital Heart Defect	Y	N
Convulsions/Epilepsy/ Seizures	Y	N
Currently Pregnant	Y	N
Diabetes	Y	N
Difficulty Breathing	Y	N
Diphtheria	Y	N
Drug/ Alcohol Abuse	Y	N
Emphysema	Y	N
Endocrine/ Thyroid Problems	Y	N
Fever Blisters	Y	N
Glaucoma	Y	N
Handicaps/ Disabilities Specify:_____	Y	N
Hearing Impairment	Y	N
Heart Attack/ Stroke	Y	N
Heart Murmur	Y	N
Heart Problems	Y	N
Hemophilia	Y	N
Hepatitis	Y	N
Herpes	Y	N
High/ Low Blood Pressure	Y	N
HIV +/ AIDS	Y	N
Kidney/ Liver Problems	Y	N
Lupus	Y	N
Measles	Y	N
Mitral Valve Prolapse	Y	N
Mumps	Y	N
Polio	Y	N
Psychiatric Problems	Y	N
Radiation Treatment	Y	N
Rheumatic/ Scarlet Fever	Y	N
Severe/ Frequent Headaches	Y	N
Shingles	Y	N
Sickle Cell Disease/ Traits	Y	N
Sinus Problems	Y	N
Tuberculosis (TB)	Y	N
Ulcer/ Colitis	Y	N
Venereal Disease	Y	N

List any other serious medical condition(s) that apply or any medications being taken:

_____

_____

_____