

Please, print both pages of this form. Then complete all sections and bring it to our office on your initial consultation appointment.

Brett Gluck D.M.D., M.S., P.C.

Specialist in Orthodontics and Dentofacial Orthopedics
Adults and Children

2455 Old Milton Parkway Alpharetta, GA 30009 | 6130 Abbots Bridge Road Johns Creek, GA 30097
(770) 664-6003 | (770) 664-7987 fax

| PATIENT INFORMATION | |
|-------------------------------|-----------------|
| Title/First/Middle/Last Name: | |
| Nickname: | |
| Street: | |
| City/State/Zip: | |
| SS #: | Home #: |
| Birthday: | Work #: |
| _ Female _ Male | Cell #: |
| Emergency Contact Name: | |
| Emergency Contact Phone #: | |
| Employer (if applicable): | |
| Street: | City/State/Zip: |
| Referred by: | |
| General Dentist: | |
| Email Address: | |

| ACCOUNT INFORMATION (if not the same as above) | | | |
|---|----------|------------------------------------|----------|
| PRIMARY RESPONSIBLE PARTY | | SECONDARY RESPONSIBLE PARTY | |
| Title/First/Middle/Last Name: | | Title/First/Middle/Last Name: | |
| Relationship to Patient: | | Relationship to Patient: | |
| Street: | | Street: | |
| City/State/Zip: | | City/State/Zip: | |
| SS #: | Home #: | SS #: | Home #: |
| Birthday: | Work # : | Birthday: | Work # : |
| [] Female [] Male | Cell #: | [] Female [] Male | Cell #: |
| Employer (if applicable): | | Employer (if applicable): | |
| Street: | | Street: | |
| City/State/Zip: | | City/State/Zip: | |

| INSURANCE INFORMATION | |
|---|--|
| PLAN I (Primary responsible party) | PLAN II (secondary responsible party) |
| Carrier Name: | Carrier Name: |
| Phone #: | Street: |
| Group #: | Group #: |

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| MEDICAL AND DENTAL HISTORY | | | | | |
|---|--------------------------------|----------|-------------------------------|----------|------------------------------|
| PATIENT NAME , Title/First/Middle/Last Name: | | | | | |
| YES / NO | | YES / NO | | YES / NO | |
| [] [] | Anemia | [] [] | Asthma / Arthritis | [] [] | Blood Transfusion |
| [] [] | Cancer / Chemotherapy | [] [] | Congenital Heart Defect | [] [] | Diabetes / Tuberculosis (TB) |
| [] [] | Difficulty Breathing | [] [] | Drug / Alcohol Abuse | [] [] | Emphysema / Glaucoma |
| [] [] | Epilepsy / Seizures | [] [] | Fever Blisters / Herpes | [] [] | Hay Fever |
| [] [] | Heart Attack / Stroke | [] [] | Heart Murmur | [] [] | Heart Surgery / Pacemaker |
| [] [] | Hemophilia / Abnormal Bleeding | [] [] | Hepatitis | [] [] | High / Low Blood Pressure |
| [] [] | HIV + / AIDS | [] [] | Hospitalized for any Reason | [] [] | Kidney Problems |
| [] [] | Mitral Valve / Prolapse | [] [] | Psychiatric Problems | [] [] | Rheumatic / Scarlet Fever |
| [] [] | Severe / Frequent Headaches | [] [] | Shingles | [] [] | Sinus / Airway Problems |
| [] [] | Ulcers / Colitis | [] [] | Venereal Disease | [] [] | Regular Radiation Exposure |
| [] [] | Wear Contact Lenses | [] [] | Pregnant (Women) | [] [] | Nursing (Women) |
| [] [] | Allergies to Medications | [] [] | Clicking / Popping of the Jaw | [] [] | Locking of the Jaw Joint |
| [] [] | Pain of the Jaw / Ear | [] [] | Clench or Grind Teeth | [] [] | Injury to the Mouth, Teeth |
| [] [] | Speech Problems / Therapy | [] [] | Finger / Thumb Habit | | |

Are you taking any medications? What? Why? _____

What are your main concerns with regard to your teeth? _____

Have you had previous orthodontic treatment? When? _____

Have you had a previous orthodontic evaluation? _____

When was your last dental exam / cleaning? _____

What tooth extractions, if any, have you had? When? _____

Was periodontal (gum) treatment performed previously? When? _____

PATIENT / PARENT SIGNATURE _____ **DATE** _____

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