

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 Georgia 30004
 (770) 664-6003 | (770) 664-7987 fax

PATIENT INFORMATION	
Title/First/Middle/Last Name:	
Nickname:	
Street:	
City/State/Zip:	
SS #:	Home #:
Birthdate:	Work #:
<input type="checkbox"/> Female <input type="checkbox"/> 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 #:
Birthdate:	Work #:	Birthdate:	Work #:
<input type="checkbox"/> Female <input type="checkbox"/> Male	Cell #:	<input type="checkbox"/> Female <input type="checkbox"/> 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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