GASTON ORTHODONTICS

NEW PATIENT INFORMATION FOR ADULTS

The following information is required to accurately diagnose and correctly treat your bite and teeth problems. All information is strictly confidential and, although some questions may seem unimportant at the moment, they may be vital in case of emergency. Our staff will be happy to assist you with any questions you might have.

Patient Information

First Name: _____ Last Name: _____
Birth date: _____ Soc. Sec. #: ____/____/_____
Address :_____
Cell Phone: _____ Email: _____
Employer: _____ Work Phone: _____

Dental Insurance

Policy Holder's Name: _____ Birthdate: _____
Policy Holder's Soc. Sec. #: _____/_____/_____
Employer: _____ Insurance Co. Name_____
ID number: _____ Group#: _____ Insurance co. Phone #_____
Insurance Co. Address_____

Do you have Dual Coverage? Yes No

Policy Holder's Name: _____ Birthdate: _____
Policy Holder's Soc. Sec. #: _____/_____/_____
Employer: _____ Insurance Co. Name_____
ID number: _____ Group#: _____ Insurance co. Phone #_____
Insurance Co. Address_____

If the office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for any co-payment, deductibles, and services that my insurance may not cover.

_____
Signature of parent or guardian Date

Emergency Contact

Name: _____ Relationship: _____
Home Phone: _____ Cell Number: _____

816 East Franklin Blvd, Gastonia, NC 28054 Phone: (704)671-4051 Fax: (704)671-4052

GASTON ORTHODONTICS

NEW PATIENT INFORMATION FOR ADULTS

Medical History

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication?
Yes No Is the patient allergic to any medication?
Yes No History of a major illness?
Yes No Has the patient had any operations?_____
Yes No Ever been involved in a serious accident?
Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only: Is the patient pregnant? Yes No

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Epilepsy	Nervous Disorders
Anemia	Gastrointestinal Disorders	Oral Herpes
Arthritis	Heart Problems	Pneumonia
Asthma or Hayfever	Heart Murmur	Prolonged Bleeding
Bone Disorders	Hepatitis/Liver problems	Radiation/Chemotherapy
Congenital Heart Defect	High Blood Pressure	Rheumatic Fever
Diabetes	HIV/ Aids	Tuberculosis
Dizziness	Kidney problems	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?
_____

PATIENT AUTHORIZATION-PLEASE SIGN BELOW

I understand that the information I have given is correct to the best of my knowledge,
That it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes
In my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date

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NEW PATIENT INFORMATION FOR ADULTS

Dental History

General Dentist: _____ Date of last visit: _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient presently in any dental pain? _____
Yes No Has the patient ever lost or chipped any teeth?
Yes No Have there been any injuries to face, mouth, or teeth?
Yes No Is any part of your mouth sensitive to temperature? Where?
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing?_____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather?
Yes No Experience jaw clicking or popping?
Yes No Aware of clenching or grinding teeth during the day?
Yes No Experience "tension" headaches?
Yes No Has the patient ever experienced chronic ringing in the ears?
Yes No Does the patient need extra help with instructions?
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Are you aware that some appointments will be during school/work hours?
Yes No What concerns you most about your teeth?

Orthodontic Benefits

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the orthodontist at Gaston Orthodontics to perform a complete orthodontic evaluation to include digital photos, a cephalometric flim, and a panoramic film.

Signature: _____

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Privacy Authorization

This form is optional under the new patient privacy regulations recently issued by the united states of the human health service. We have elected to use this form. Prior to commencing your Dental treatment, you should review, sign and date this form. Your protected health information (i.e., individually identifiable information such as, names, dates, phone/fax number, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment , payment of your account or health care cooperation.

This consent also pertains to any electronic filling and website consent. You have the right to review our office policy notice prior to signing this consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to and may not honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any cation has been taken in reliance of the consent .Thank you for your cooperation. Please let us know if you have any questions.

Patient's name

Patient/Parent Signature

Date

GASTON ORTHODONTICS

NEW PATIENT INFORMATION
FOR ADULTS

Office Policy

Thank you for choosing Gaston Orthodontics for your orthodontic care. We are here to make your visit a pleasant and fun experience. Our office is designed to put you and the patient at ease and our staff is devoted to assist you with any questions.

Office Policy:

- When you arrive at the office, be sure to check in with the receptionist so that we know you have arrived
- NO food or drinks are allowed in our office.
- Please do not leave small children (infants, toddlers, children in strollers) unattended
- Parents/Guardians must stay in the building at all times while the patient is being treated, in case we need to discuss the patient's treatment progress. (If the patient is left unattended, we will not be able to treat them)
- If you are more than **10 minutes** late for your appointment there is a possibility that we will be unable to see you and have to request for you to reschedule. Please contact us as soon as you know that you will be late so that we can work with you.
- In order to keep our schedule updated and be respectful to our other patients, we require a 24 to 48 hours advance notice to cancel or change any appointment.
- Because we schedule appointments 4-6 weeks in advance for please understand that canceling at the last minute or no showing an appointment may result in an appointment 4-6 weeks out

_____

Initials

If you have any questions, please feel free to ask the receptionist, and she will gladly escort you to the clinic area to speak with the doctor and/or assistant to discuss all the questions you have.

I have read and understood the office policy for Gaston Orthodontics.

Name: _____

Signature: _____ Date: _____

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NEW PATIENT INFORMATION FOR ADULTS

REFERRALS:

We would like the opportunity to evaluate anyone you may know such as siblings (age beginning at 7), other family members or friends who would like to inquire about orthodontic treatment.

Please list names and numbers below, that we may contact in the near future for an evaluation:

Name:	Relationship:	Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

We appreciate you ☺

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GASTON ORTHODONTICS

NEW PATIENT INFORMATION FOR CHILDREN

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Patient Information

Patient Name: _____ Date: _____
Sex: _____Age:_____ Birthdate: _____ Preferred Name: _____
Address: _____
Cell Phone: _____ Email: _____
How did you hear about us? _____

Responsible party for Account

First Name: _____ Last Name: _____
Relation to the Patient: _____ Birthdate: _____ Soc. Sec. #: ____/____/_____
Address (if different from Patient): _____
Cell Phone: _____ Email: _____
Employer: _____ Work Phone: _____

Dental Insurance

Policy Holder's Name: _____ Birthdate: _____
Policy Holder's Soc. Sec. #: _____/_____/_____
Employer: _____ Insurance Co. Name_____
ID number: _____ Group#: _____ Insurance co. Phone #_____
Insurance Co. Address_____

Do you have Dual Coverage? Yes No

Policy Holder's Name: _____ Birthdate: _____
Policy Holder's Soc. Sec. #: _____/_____/_____
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Signature of parent or guardian Date

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Patient History

Medical History

Physician _____ Date of Last Visit _____
Address _____ Phone _____

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NEW PATIENT INFORMATION FOR CHILDREN

Dental History:

Please Check/Circle all that apply:

As the Patient had recent or past injuries to the mouth: Y/N Why? _____
Concerns or current Thumb, finger, lip sucking? Y/N
Does the patient have current Mouth-breathing when asleep/awake? _____
More than average amount of decay? Y/N
Any missing permeant teeth? Y/N
Any extra permeant teeth? Y/N
Any teeth removed by extraction? Y/N
Is there a tongue thrusting problem? Y/N
Any speech problems? Y/N
Any difficulty in swallowing or chewing? Y/N
Any pain or clicking on opening mouth? Y/N

Does the Patient have any food or Medicine Allergies: _____

Please list any drugs or medications being taken currently: _____
_____

Name of the Patient's General Dentistry: _____ Phone Number: _____

Date of last cleaning? _____

What are your concerns regarding your child's orthodontic treatment? (Crowding, Overbite, Etc.)
_____

Orthodontic Benefits

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the orthodontist at Gaston Orthodontics to perform a complete orthodontic evaluation to include digital photos, a cephalometric flim, and a panoramic film.

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Patient's name

Patient/Parent Signature

Date

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Parents Name: _____

Parents Signature: _____ Date: _____

REFERRALS:

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_____	_____	_____
_____	_____	_____

We appreciate you ☺

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