Dr. Stephen Gurza and Staff Welcome you to The Brace Place®

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. If you wish, you may request a copy of our privacy policy from the reception desk.

Date (d/m/y): _____/_____/ 200___ ***All fields must be completed***

I. PATIENT'S PERSONAL HISTORY

Patient's Name: _____ ☐ Male ☐ Female

Date of Birth (d/m/y): _____ Age:_____ E-Mail: _____

Patient's Address: _____

_____Apt:_____ Postal Code: _____

Patient's Home Phone: (____)_____Cell:(____)_____ Work: (____)_____Ext:_____

Occupation: _____Employer:_____

Do you have any third party dental or orthodontic insurance coverage? ☐ No ☐Yes

Patient's Dentist: Dr._____; Who referred you to us?_____

II. If PATIENT IS A MINOR

Name of person giving this information:

Last Name:_____ First Name:_____ Relationship:_____

Mother: Last Name: _____First Name: _____ E-Mail:_____

Father: Last Name: _____ First Name: _____ E-Mail:_____

Please indicate telephone numbers where you can be reached during business hours in case of an emergency.

Mother's Cell Phone: (____)_____ Bus. Telephone: (_____)_____Ext:_____

Father's Cell Phone: (____)_____ Bus. Telephone: (_____)_____ Ext:_____

III. RESPONSIBLE PARTY

Name of person responsible for account: ☐ same as above; Mr. / Mrs._____

Occupation: _____Employer:_____

Billing Address [if different from patient's]: _____ Postal Code:_____

Is the patient covered under any third party dental or orthodontic insurance coverage? ☐ No ☐ Yes

IV. FAMILY HISTORY OF PATIENT [if a minor]

School: _____ Grade: _____ Special Needs: _____

Sports or Hobby Interests:_____ Sports Mouthguard required: ☐ No ☐ Yes

Does the patient have any siblings?[ages and gender] _____

V. REASONS FOR THIS ORTHODONTIC VISIT: Please describe the problems with the patient's [your] teeth:

_____

_____

Has patient seen an orthodontist in the past? ☐ No ☐ Yes if yes state when:_____

[please turn page over]

VI. PATIENT'S MEDICAL HISTORY

Physician's Name: _____ Telephone: (_____)_____

When was your last visit to the physician? _____

What was the reason for the visit? _____

Present Health: ☐ Good Current Issues:_____

If patient has or has had any of the following, please circle it:

Rheumatic Fever Heart Murmur Hepatitis Epilepsy Herpes Arthritis HIV+ AIDS Allergies Asthma Diabetes Sinusitis Heat Disease Sensitive Stomach Jaundice Mononucleosis Ulcers Tuberculosis Stroke Mental Disease High or Low Blood Pressure Blood Nerves Thyroid Liver Kidney Respiratory Problems Multiple Sclerosis Glaucoma Muscular Dystrophy Venereal Disease

Antibiotics required prior to dental visit: ☐ No ☐ Yes If yes please state type of antibiotic: _____

Congenital Defects [birth defects]: ☐ No ☐ Yes _____

Speech Problems [please note difficult sounds]: _____

Are patient's tonsils and adenoids: ☐ Present ☐ Removed Date removed:_____

Mouth Breathing: ☐ No ☐ Yes If yes has patient seen ENT specialist: ☐ No ☐ Yes When:_____

Snoring: ☐ No ☐ Yes

Does patient have any Allergies? ☐ No ☐ Yes If yes please list:_____

VII. FOR CHILDREN ONLY:

Attention Disorders (A.D.D.) ☐ No ☐ Yes If yes please note medications:_____

VIII. WOMEN ONLY:

Are you pregnant? ☐ No ☐ Yes Due date:_____

IX. PATIENT'S DENTAL HISTORY

History of trauma: ☐ head ☐ teeth ☐ No ☐ Yes If yes, describe:_____

How often do you see your Dentist? ☐ Twice Yearly ☐ Yearly ☐ Infrequently ☐ Only when in pain

When was your last dental checkup and cleaning?_____

How often do you brush your teeth? ☐ Twice daily ☐ Once daily ☐ Infrequently

Is there a history of thumb or finger sucking? ☐ No ☐ Yes If yes, when stopped? _____

Are you tense during dental appointments? ☐ Slightly ☐ Moderately ☐ Extremely

Are you troubled by headaches, clicking and/or pain in the jaw joints? ☐ No ☐ Yes Please describe:_____ ___

Do your gums bleed excessively when you brush your teeth? ☐ No ☐ Yes If yes, have you seen a Periodontist? ☐No ☐Yes

Is there a history of:

Teeth Grinding…….	☐ No	☐ Yes	Lip Biting…….....	☐ No	☐ Yes
Tongue Thrusting…….	☐ No	☐ Yes	Nail Biting…….…..…	☐ No	☐ Yes
Missing Teeth……..	☐ No	☐ Yes	Canker Sores……	☐ No	☐ Yes

SIGNATURE: _____

Office use only
UD_____ _____
UD_____ _____