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Bradley Goldsamt, DDS
WELCOME TO OUR PRACTICE

Date: ____________________
Who may we thank for referring you? ____________________
Briefly tell us why you chose our office: ____________________

Emergency contact : ***If we need to contact you to reschedule an appointment due to inclement weather, etc., please leave telephone number where you can be reached or a message can be left.***
Name: ____________________ ***Telephone #:*** ____________________

Tell us about yourself:

Name ____________________
Last *First*
Mr. Mrs. Ms. Dr.
Single ___ *Married* ___ *Divorced* ___
*Widowed*___ *Separated*___

I prefer to be called: ____________________
Birth date: ____________ *Age:* ________
SS# ____________________
Home address: ____________________
____
Employer: ____________________
Home: ____________________
Cell #: ____________________
Employer's Name &Address: ____________________
____
Occupation: ____________________
When is the best time to reach you? ____________

Your General Dentist: ____________________
____
Address: ____________________
Last Visit: ____________________
Other family members seen by us: ____________
☺E-Mail address☺
☺>
In the event of an emergency, is there someone who lives near you that we should contact?
Their name: ____________________
Relation: ____________________
Cell: # ____________________
Home # ____________________

2: Spouse Information:

Name: ____________________
Employer: ____________________
Work # ____________________
SS#: ____________________
Date of Birth: ____________________

Primary Insurance: Coverage: Yes_____ **No**_____

Insured's Name: ____________________
Relation: ____________________
Insured date of birth: ____________________
Insured's SS# ____________________
Insured Employer: ____________________
Insurance Co Name: ____________________
Address: ____________________
Telephone # ____________________

***Secondary Orthodontic Coverage*: Yes**_____ **No**_____

Insured's Name: __________ ***Relation*** __________
Insured's Birthday: ____________________
Insured's SS# ____________________
Insured's Employer:
____

Insurance Company Name: ____________________

Insurance Co. Address: ____________________

Insurance Co Telephone #: ____________________

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☺-more on the back!

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Medical History:

Physician's Name ______________________ **Telephone #** ______________ **Last Visit:** __________

Are you taking any prescription drugs? Yes ☐ No ☐
If yes, please list each one: ______________________________________

Why did you select our office? ______________________________________

Please answer "Yes" or "No"

Y ☐ No ☐ Artificial heart valves/shunts/patch/catheter
Y ☐ No ☐ History of endocarditis of the heart
Y ☐ No ☐ Congenital (present from birth) heart condition-other than heart murmur
Y ☐ No ☐ Any artificial joints/pins/screws/metal rods or plates in body
Y ☐ No ☐ Cardiac surgery-please explain: ______________________

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

Y	N	Heart Murmur	Y	N	Heart Attack/Stroke
Y	N	Allergic To Latex	Y	N	Allergic to Metal/Nickel/Jewelry
Y	N	Asthma	Y	N	Arthritis
Y	N	Attention Deficit Disorder (A.D.D.)	Y	N	Cancer/Chemotherapy/Radiation
Y	N	Convulsions /Epilepsy/ Seizures	Y	N	Diabetes
Y	N	Fainting	Y	N	Hemophilia (Abnormal Bleeding)
Y	N	Hepatitis	Y	N	High/Low Blood Pressure
Y	N	HIV/AIDS	Y	N	Psychiatric problems
Y	N	Severe /Frequent Headaches	Y	N	Sinus Problems
Y	N	Tuberculosis	Y	N	Allergic to Penicillin or Amoxicillin

Are you currently pregnant? Yes ☐ No ☐ **Have you ever been hospitalized for any reason? Y ☐ N ☐**

Explain: ______________________________________
Are you currently taking any prescription medications for bone density disorders? Y ☐ N ☐
Please list any medical conditions you have ever had: ______________________________________

____

Please list any other allergies or drugs you are allergic to: ______________________________________

Dental History

What are the main concerns you wish orthodontics to accomplish? ______________________
Have you ever had injury to your mouth, teeth or chin?.................................... Yes ___ No ___
Have you ever had or been evaluated for orthodontic treatment? .... Yes ___ No ___
Have you ever had a serious or difficult problem associated with dental work?.................... Yes ___ No ___
If yes, please explain: ______________________________________
Do you now have or ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ?.................. Yes ___ No ___
Do you have any speech problems?.. Yes ___ No ___
Do you generally breathe through your mouth .... Yes ___ No ___
Do you have any missing or permanent teeth? .... Yes ___ No ___
Have you ever been treated of diagnosed with periodontal (gum) disease?........................ Yes ___ No ___

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status:

Signature: *Date:*

Signature on File: I authorize my doctor to act as my agent and authorize my signature to be used in place of the original on insurance claims on behalf of the patient. I also authorize payments directly to the doctor otherwise payable to me:

Signature: ______________________________________

DO NOT WRITE IN THIS SPACE

I have reviewed the medical/dental information above with the patient herein. Initials______ Date: _______

Doctor's Comments: ______________________________________