

Bradley Goldsamt, DDS

WELCOME TO OUR PRACTICE

M

Date: _____

Who may we thank for referring you here today? _____
 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.
 Telephone #: _____

ABOUT YOUR CHILD:

Name: _____
 Male _____ Female _____
 Birthday: _____
 Home Tel. # _____
 Home Address: _____

Child's General Dentist Name: _____
 Address: _____
 Tel #: _____
 Date of last visit: _____
 Who is accompanying your child today?
 Name: _____
 Relation: _____

Do you have legal custody of this child?
 Yes _____ NO _____

Parent's Marital Status:
 Single _____ Married _____ Widowed _____
 Divorced _____ Separated _____

☺Family email address☺

☺>

PARENT INFORMATION:

Mother:
 Name: _____
 Address: _____
 Employer: _____
 Social Security # _____
 Date of birth: _____
 Work # _____
 Cell # _____

Father:

Name: _____
 Address: _____
 Employer: _____
 Social Security # _____
 Date of birth: _____
 Work # _____
 Cell # _____

INSURANCE: Primary Orthodontic Coverage:
 Yes ___ No ___

Insured's Name: _____
 Date of birth: _____
 Social Security # _____
 Relationship to patient: _____
 Insured Employer: _____

Insurance Co. Name: _____
 Ins. Co. Tel #: _____
 Address: _____

Group#, Plan or Local # _____

Secondary Orthodontic Coverage:
 Yes ___ No ___

Insured's Name: _____
 Date of Birth: _____
 Social Security # _____
 Relationship to Patient: _____
 Insurance Co. Name: _____
 Ins. Co. Tel #: _____
 Address: _____
 Group#, Plan or Local # _____

Medical History:



Name of child's physician: _____ Telephone # _____

Last Visit: _____

Please list all drugs your child is taking: _____

Please list all drugs your child is allergic to: _____

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: _____

Has the patient ever had any of the following diseases or medical problems?

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

Is the patient currently pregnant? Yes No Has the patient ever been hospitalized for any reason? Y N

If yes, please explain: _____

Please list any medical problems the patient has ever had: _____

- | | | |
|--|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Thumb Sucking | Y <input type="checkbox"/> N <input type="checkbox"/> Nail Biting | Y <input type="checkbox"/> N <input type="checkbox"/> Speech Problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> Mouth Breather | Y <input type="checkbox"/> N <input type="checkbox"/> Tongue Thrust | Y <input type="checkbox"/> N <input type="checkbox"/> Nursing Bottle Habits |
| Y <input type="checkbox"/> N <input type="checkbox"/> Lip sucking/Biting | Y <input type="checkbox"/> N <input type="checkbox"/> Clenching/Grinding Teeth | |

Dental History

Has your child ever been evaluated for orthodontic treatment? Yes ___ No ___

Has your child even been informed of any missing or extra permanent teeth? Yes ___ No ___

Has you child ever experienced pain or discomfort in the jaw joint (TMJ/TMD)? Yes ___ No ___

Has your child ever had any injuries to face, mouth, teeth or chin? Yes ___ No ___

If yes, please explain: _____

What are the main concerns you would like orthodontics to address? _____

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: _____ Date: _____

DO NOT WRITE BELOW THIS LINE

I have reviewed the medical/dental information with the patient herein. Initials _____ Date: _____

Doctor's Comments: _____