GeorgeOrthodontics
more than beautiful smiles

Adult Patient Information

Patient's Name ____ Today's Date ____________________

Birth Date____/_____/_____ Age______ ❑M ❑F Email address:____________________________________

Mailing Address ____________________________________ City _______________ State _______ Zip __________

Home Phone________________________ Work Phone ____________________ Cell Phone ____________________

Employer ______________________________ Occupation ________________________ Years Employed ________

Dentist ____ Date of Last Dental Check Up ____________________

Whom may we thank for referring you to our office?____

Responsible Party Information

❑Self ❑Spouse ❑Other Name ____________________________________ ❑Single ❑Married ❑Divorced ❑Separated

Address ______________________________________ City ________________ State ________ Zip _____________

Home Phone ______________________ Work Phone ____________________ Cell Phone________________________

Social Security Number ______- ______-_______ Birth Date _____/_____/_____ Relationship to Patient ____________________

Employer ______________________________ Occupation __________________________ Years Employed _______

Insurance Information

Policy Holder's Name ___________________________ Birth Date ______/______/_____ SSN _______ - ______ - _______

Insurance Company ______________________________ ID No. __________________ Group No. _____________

Insurance Co Address ________________________________City __________________ State ______ Zip _________

Phone ________________________

2nd Insured's Name ____________________________ Birth Date ______/______/_____ SSN _______ - ______ - _______

Insurance Company ______________________________ ID No. __________________ Group No. _____________

Insurance Co Address ________________________________City __________________ State ______ Zip _________

Phone ________________________

Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company.

Emergency Contact Information

Name of nearest relative not living with you:________________________________Phone:____________________

Please continue on back of page

Dental History

What is your main concern?____

____

Are you interested in: (Please indicate all that apply)

❑ Information ❑ Treatment now ❑Clarification of previous or conflicting information

1. Have there been injuries to the face, mouth, or teeth? ❑ Yes ❑ No
2. Do you have any speech problems? ❑ Yes ❑ No
3. Have you been informed of any missing or extra permanent teeth? ❑ Yes ❑ No
4. Has any previous orthodontic treatment been rendered? ❑ Yes ❑ No
5. Do you suffer from any jaw joint problems such as pain, clicking, popping, etc.? ❑ Yes ❑ No
6. Do you grind or clench your teeth during the day or night? ❑ Yes ❑ No
7. Teeth difficult to clean? ❑ Yes ❑ No
8. Awareness of any gum or bone problem around teeth? ❑ Yes ❑ No
9. Concerned about the appearance of your teeth? ❑ Yes ❑ No

Other:____

Medical History

Name of your physician ______________________Date of last exam______________________

1. Are you in good health? ❑ Yes ❑ No

2. Do you have a health problem? ❑ Yes ❑ No If yes, explain______________________

3. Do you have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc,)?

❑Yes ❑No If yes, please list: ______________________

4. Please list current prescription medications you are taking: ______________________

5. Have you been treated by a physician for any of the following conditions? (Check any that apply)

❑ Problems at Birth	❑ Hepatitis/Liver Disease	❑ Seizures
❑ Heart Disease/Murmur	❑ Tuberculosis	❑ Cleft Lip/Palate
❑ Rheumatic Fever	❑ Kidney Disease	❑ Speech or Hearing Problems
❑ Sickle Cell Anemia	❑ Cancer/Radiation Therapy	❑ Tonsil, Adenoid, Sinus Problems
❑ Anemia/Hemophilia	❑ Cerebral Palsy	❑ Emotional/Behavior Problems
❑ Diabetes	❑ Arthritis	❑ Learning Disabilities
❑ AIDS or HIV	❑ Asthma	❑ Growth Problems

Other:____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any *changes*. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees.

____ ______________________

Responsible party signature Date

MICHAEL L. GEORGE, D.D.S., M.S.D., P.S.

4001 Colby Avenue, Everett, WA 98201
Tel: (425) 258-1121 - Fax: (425)258-0479

700 Avenue D, Snohomish WA 98290
Tel: (360) 568-1519 - Fax:(360) 568-8935

www.georgeorthodontics.com