

Welcome

Acct: _____
(For office use)

As required by law, our office adheres to written policies & procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. This information is vital to allow us to provide appropriate care for you.

RICHARD E. GALLAGHER
DDS, MSO, MAJ, PhD

(PLEASE PRINT)

PATIENT INFORMATION

Name _____ Today's Date ____/____/____
(Last) (First) (M.I.)
Date of Birth ____/____/____ Sex: M F E-mail: _____
Phone: Home (____) _____ Work (____) _____ Cell (____) _____
Address _____ City _____ State _____ Zip _____
Emergency Contact: _____ Relationship: _____ Home # (____) _____ Cell # (____) _____
Referred By _____ Family Dentist _____ Physician _____
Method of Payment (If treatment is pursued.): Cash _____ Insurance _____ Other _____

Would you like your appointment emailed to you? YES or NO Would you like your appointment texted to you? YES or NO
COMPLETE THIS SECTION IF PATIENT IS A MINOR:

Father's Name _____	Mother's Name _____
Address _____	Address _____
City _____ Zip _____	City _____ Zip _____
Home # (____) _____ Work # (____) _____	Home # (____) _____ Work # (____) _____
Cell # (____) _____ E-mail _____	Cell # (____) _____ E-mail _____
Employer _____ Occupation _____	Employer _____ Occupation _____
Length of time employed at this job _____	Length of time employed at this job _____
Do mother, father and child reside together? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of children in family _____

INSURANCE INFORMATION

Dental Insurance

Additional Insurance

Insured's Name: _____	Insured's Name: _____
Relation to Patient _____ Birthdate: ____/____/____	Relation to Patient _____ Birth date: ____/____/____
Social Security # or Patient ID: _____	Social Security # or Patient ID: _____
Employer: _____ Occupation _____	Employer: _____ Occupation _____
Insurance Company: _____	Insurance Company: _____
Insurance Phone #: _____	Insurance Phone #: _____

PLEASE COMPLETE BOTH SIDES

For in Office Use:

I have received a copy of this office's *Notice of Privacy Practices*.

Signature Date

Refused Communication Barrier Emergency Other

MEDICAL HISTORY UPDATE

Changes in patient's health: _____	Changes in patient's health: _____
New medications: _____	New medications: _____
Signature of Patient or Parent/Guardian, if minor: _____	Signature of Patient or Parent/Guardian, if minor: _____
Date: _____	Date: _____

DENTAL HISTORY

Date last seen by your dentist _____ Reason for visit to your dentist _____

Previous orthodontics	Yes	No	Thumb/ Finger sucking	Yes	No	Clenching teeth	Yes	No
Sores in mouth	Yes	No	Dental surgery	Yes	No	Pain in head, face or jaw	Yes	No
Gum trouble / bleeding	Yes	No	Difficulty chewing	Yes	No	Headaches	Yes	No
Fear of dentists	Yes	No	Jaw joint problems	Yes	No	Noise or clicks in jaw joint	Yes	No
Speech problems	Yes	No	Blow/ injury to jaw / face	Yes	No	Excessive snoring	Yes	No
Nail biting / lip biting	Yes	No	Grinding (bruxing) teeth	Yes	No	Nose breathing difficult	Yes	No

Please explain any "Yes" answers to the above questions and give dates when appropriate: _____

How many times a day does the patient brush? _____ How many times a week does the patient floss? _____
 Did patient's parents have an orthodontic problem? **Mother:** Yes No **Was it treated?** Yes No **Father:** Yes No **Was it treated?** Yes No
 Please describe in your own words what concerns you have about your teeth or your child's teeth. _____

MEDICAL HISTORY

Asthma	Yes	No	Heart attack or stroke	Yes	No	Abnormal bleeding	Yes	No	Eating disorder	Yes	No
Bronchitis	Yes	No	Glaucoma	Yes	No	Anemia	Yes	No	Malnutrition	Yes	No
Emphysema	Yes	No	Epilepsy	Yes	No	Blood transfusion-Date?__	Yes	No	Gastrointestinal disease	Yes	No
Sinus trouble	Yes	No	Fainting spells or seizures	Yes	No	Hemophilia	Yes	No	Persistent heartburn	Yes	No
Tuberculosis	Yes	No	Neurological disorders	Yes	No	AIDS or HIV infection	Yes	No	Ulcers	Yes	No
Hepatitis or liver disease	Yes	No	Injuries to head/neck	Yes	No	Arthritis	Yes	No	Thyroid problems	Yes	No
Heart disorders	Yes	No	Chronic pain	Yes	No	Autoimmune disease	Yes	No	Excessive urination	Yes	No
High blood pressure	Yes	No	Diabetes Type 1 or II	Yes	No	Rheumatoid arthritis	Yes	No	Mental health disorder	Yes	No
Heart murmur	Yes	No	Kidney problems	Yes	No	Systemic lupus erythema.	Yes	No	Night sweats	Yes	No
Mitral valve prolapse	Yes	No	Persistent swollen glands	Yes	No	Hormone abnormalities	Yes	No	Osteoporosis	Yes	No
Artificial heart valves	Yes	No	Chest pain upon exertion	Yes	No	Cancer/Radiation treatment	Yes	No	Severe headaches/migraines	Yes	No
Rheumatic fever	Yes	No	Joint replacement	Yes	No	Nose or throat problems	Yes	No	Recurrent infections-Type?	Yes	No

Are you taking, or have you taken, any diet drugs such as Pondimin, Redux, or phen-fen? Yes No

Are you taking or scheduled to begin taking either alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? Yes No

Have you ever received treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? Yes No

Please explain any "Yes" answers to the above questions and give dates when appropriate: _____

ALLERGIES – Are you allergic to or have had a reaction to:

Local anesthetics	Yes	No	Codeine or other narcotics	Yes	No	Hay fever/seasonal	Yes	No
Aspirin	Yes	No	Metals	Yes	No	Animals	Yes	No
Penicillin or other antibiotic	Yes	No	Latex (rubber)	Yes	No	Food	Yes	No
Sulfa drugs	Yes	No	Iodine	Yes	No	Other	Yes	No

To all YES responses, specify type of reaction: _____

Are you now under the care of a physician? Yes No Physician Name: _____ Phone: (____) _____

Date of last physical exam _____ Have there been any changes in your general health within the past year? Yes No

If yes, what condition is being treated? _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No If Yes, please explain: _____

Are you taking or have you recently taken any prescription or over the counter medicines? Yes No If Yes, please list names: _____

FEMALES ONLY: Are you pregnant? Yes No If so, how many weeks? _____ Are you nursing? Yes No

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No Explain _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of truthful health history and that this office will rely on this information for treating me. I will not hold Dr. Gallagher, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form. I authorize my insurance company to directly pay Dr. Richard R. Gallagher the insurance benefits otherwise payable to me. I authorize Dr. Gallagher to release all information necessary to secure payment of benefits.

Signature of Patient or Parent/Guardian, if minor

Date

Signature of Orthodontist

Date