Acct: ____________
(For office use)

Welcome

RICHARD B. GALLAGHER
DDS, MSD, MSE, PHD

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.

(PLEASE PRINT)

PATIENT INFORMATION

Name ____________ (Last) ____________ (First) ____________ (M.I.) Today's Date ___/___/___

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 ____________
Address ____________
City ____________ Zip ____________
Home # (___) ____________ Work # (___) ____________
Cell # (___) ____________ E-mail ____________
Employer ____________ Occupation ____________
Length of time employed at this job ____________
Do mother, father and child reside together? ☐ Yes ☐ No

Mother's Name ____________
Address ____________
City ____________ Zip ____________
Home # (___) ____________ Work # (___) ____________
Cell # (___) ____________ E-mail ____________
Employer ____________ Occupation ____________
Length of time employed at this job ____________
Number of children in family ____________

INSURANCE INFORMATION

Dental Insurance

Insured's Name: ____________
Relation to Patient ____________ Birthdate: ___/___/___
Social Security # or Patient ID: ____________
Employer: ____________ Occupation ____________
Insurance Company: ____________
Insurance Phone #: ____________

Additional Insurance

Insured's Name: ____________
Relation to Patient ____________ Birth date: ___/___/___
Social Security # or Patient ID: ____________
Employer: ____________ Occupation ____________
Insurance Company: ____________
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: ____________
New medications: ____________
Signature of Patient or Parent/Guardian, if minor:
____
Date: ____________

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

PLEASE CIRCLE EACH YES OR NO QUESTION INDIVIDUALLY FOR ALL BELOW QUESTIONS.

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