



Patient's Full Name _____ Preferred Name _____ Age _____ Birth Date _____
 Address _____ City _____ State _____ Zip _____
 How long at this address? _____ Rent or Own? _____ Home Phone _____
 Social Security # _____ Email _____ Cell Phone _____
 Occupation _____ Employed By _____ How long? _____ Work Phone _____
 Spouse's Name _____ Employed By _____ How long? _____ Work Phone _____
 Spouse's Social Security # _____

Children <input type="checkbox"/> Yes <input type="checkbox"/> No	Name Age	Name Age	Name Age	Name Age
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Person Responsible for Account _____ Relationship to Patient _____
 Address _____ City _____ State _____ Zip _____ S.S.# _____
 Employer _____ How long? _____ Home Phone _____ Work Phone _____
 Do you have orthodontic insurance coverage? _____ Insurance Co. _____ ID# _____
 Insured's Name _____ D.O.B _____ S.S.# _____
 I authorize Dr. Gluck to file insurance benefits on my behalf _____
 Benefits directed to reimburse insured Direct benefits to A. Joel Gluck DDS, MS

Dentist _____ Physician _____
 Whom may we thank for referring you to our office? _____

Medical History Have you ever had (or have) any of the following: (Please check)

<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emotional Problems
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Prolonged Bleeding
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Fainting or Dizziness
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Speech/Hearing Problems	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Kidney Involvement	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Transfusion	
<input type="checkbox"/> Endocrine Problems	<input type="checkbox"/> Major Operation	<input type="checkbox"/> Other _____	

Is patient presently under the care of a physician? Yes No If so, for what? _____
 List all medicines (including herbal supplements) patient is currently taking _____
 List all drugs or medicines to which patient has had a reaction or is allergic _____
 Have tonsils and/or adenoids been removed? Yes No If yes, what age? _____

Dental History Have you ever experienced any of the following: (Please check)

<input type="checkbox"/> Injury to Face/Teeth/Jaws/Head	<input type="checkbox"/> Periodontal Disease	<input type="checkbox"/> Clicking/Popping in Jaw Joint
<input type="checkbox"/> Thumb/Finger Sucking	<input type="checkbox"/> Root Canal Treatment	<input type="checkbox"/> Pain in Jaw Joint or Muscles
<input type="checkbox"/> Mouth Breathing	<input type="checkbox"/> Extraction of Teeth	<input type="checkbox"/> Jaw Joint Locked or Out of Joint
<input type="checkbox"/> Clenching or Grinding Teeth	<input type="checkbox"/> Extra or Missing Permanent Teeth	<input type="checkbox"/> Other Dental Problems

Are you on a regular 6-month or yearly recall schedule with your family dentist? Y N
 Have you previously seen an orthodontist? Y N
 Has any other member of the family undergone orthodontic treatment? Y N
 Were you aware that an orthodontic problem might exist before being referred to our office? Y N

What is your main reason for seeking this consultation? _____

Signature _____ Date _____