GLUCK
ORTHODONTICS

PATIENT INFORMATION RECORD

DIPLOMATE
AMERICAN BOARD
OF ORTHODONTICS

Patient's Full Name ______________________ Preferred Name ______________ Age ________ Birth Date ____________

Address ______________________________________ City __________ State _____ Zip ______

How long at this address? __________ Rent or Own? ________ School ______________ Grade ________

Father's Name ____________________ S.S.# ________________ Home Phone ____________

Occupation ______________ Employed By ______________ How long? _____ Work Phone ________

Mother's Name____________________ S.S.# ________________ Home Phone____________

Occupation ______________ Employed By ______________ How long? _____ Work Phone ________

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Responsible Party ________________ Email ____________________ Cell Phone ____________

Siblings ☐ Yes ☐ No	Name Age	Name Age	Name Age	Name Age

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 ______________ Relation to Patient __________ D.O.B _________ S.S.#__________

I authorize Dr. Gluck to file insurance benefits on my behalf X______________________________

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)

- ☐ Heart Problem
- ☐ Rheumatic Fever
- ☐ Bone Disorders
- ☐ Tuberculosis
- ☐ Kidney Involvement
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Hepatitis/Jaundice
- ☐ HIV/AIDS
- ☐ Anemia
- ☐ Diabetes
- ☐ Major Operation
- ☐ Arthritis
- ☐ Radiation Therapy
- ☐ Allergies/Asthma
- ☐ Speech/Hearing Problems
- ☐ Blood Transfusion
- ☐ Other__________
- ☐ Emotional Problems
- ☐ Prolonged Bleeding
- ☐ Fainting or Dizziness
- ☐ Frequent Headaches

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 What age? ________

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

- ☐ Injury to Face/Teeth/Jaws/Head
- ☐ Thumb/Finger Sucking
- ☐ Mouth Breathing
- ☐ Clenching or Grinding Teeth
- ☐ Periodontal Disease
- ☐ Root Canal Treatment
- ☐ Extraction of Teeth
- ☐ Extra or Missing Permanent Teeth
- ☐ Clicking/Popping in Jaw Joint
- ☐ Pain in Jaw Joint or Muscles
- ☐ Jaw Joint Locked or Out of Joint
- ☐ 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? ________________________________

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Signature ______________________________ Date ____________________

CHILD