DR. JAMES B. GRAY, DMD, PC 10930 CRABAPPLE ROAD SUITE 240 | ROSWELL, GA 30075 | 770.993.6292

DATE: ______________________

PATIENT'S FULL NAME: ______________________ PREFERRED NAME: ______________ AGE: ______

DATE OF BIRTH: __________ GENDER: ☐ F ☐ M SCHOOL: ______________ GRADE: ______

HOME ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

FATHER'S NAME: ______________ CELL: __________ EMPLOYER: __________

FATHER'S ADDRESS: ____
(if different from above) (STREET) (CITY) (STATE) (ZIP)

MOTHER'S NAME: ______________ CELL: __________ EMPLOYER: __________

MOTHER'S ADDRESS: ____
(if different from above) (STREET) (CITY) (STATE) (ZIP)

PREFERRED COMMUNICATION METHOD: ☐ PHONE ☐ TEXT ☐ E-MAIL

PREFERRED E-MAIL ADDRESS: ______________________________

DENTIST: ______________ DATE OF LAST DENTAL VISIT: ______________

REFERRED BY: ☐ DENTIST __________ (if different from above) ☐ FRIENDS __________ (please specify) ☐ INTERNET __________ (i.e Google, Healthgrades, Facebook)

☐ SCHOOL __________ ☐ OTHER __________

PATIENT'S HOBBIES, SPORTS, INTERESTS ______________________________

DOES THE PATIENT HAVE SIBLINGS? SISTERS? BROTHERS? AGES? ______________

MEDICAL HISTORY INFORMATION

☐ Y ☐ N HEART DISEASE	☐ Y ☐ N RHEUMATIC FEVER	☐ Y ☐ N EPILEPSY
☐ Y ☐ N ASTHMA	☐ Y ☐ N FAINTING OR DIZZINESS	☐ Y ☐ N ADHD/ADD
☐ Y ☐ N BLEEDING DISORDER	☐ Y ☐ N SEIZURES	☐ Y ☐ N ARTHRITIS
☐ Y ☐ N DIABETES	☐ Y ☐ N HORMONES	☐ Y ☐ N TONSILLECTOMY (YEAR:______)
☐ Y ☐ N HEPATITIS	☐ Y ☐ N EMOTIONAL DISORDER	☐ Y ☐ N ADENOIDECTOMY (YEAR:______)

IF YOU CHECKED YES ABOVE, PLEASE EXPLAIN: ______________________________

PLEASE LIST ANY OTHER MEDICAL INFORMATION OR HISTORY THAT MAY BE HELPFUL: ______________

______________________________ PHYSICIAN: ______________

MEDICATIONS NOW BEING TAKEN/REASONS: ______________________________

ALLERGIES / SENSITIVITIES: ______________________________

HAS CHILD REACHED PUBERTY? ☐ Y ☐ N MENSTRUATED (GIRLS): ☐ Y ☐ N VOICE CHANGE (BOYS): ☐ Y ☐ N

HEIGHT OF PATIENT: ______ FATHER: ______ MOTHER: ______ GROWTH OF PATIENT LAST YEAR: ______ (INCHES)

DENTAL & ORTHODONTIC HISTORY INFORMATION

HAVE ANY TEETH BEEN REMOVED BY THE DENTIST? ☐ Y ☐ N

HAS THE PATIENT SUSTAINED ANY INJURIES TO THE FACE, HEAD, OR TEETH? ☐ Y ☐ N

IF YES, PLEASE EXPLAIN: ____________________

GRINDING OF TEETH ☐ Y ☐ N SNORING ☐ Y ☐ N

MOUTH BREATHING ☐ Y ☐ N DAYTIME SLEEPINESS ☐ Y ☐ N

PREVIOUS THUMB OR FINGER SUCKING HABIT? ☐ Y ☐ N UNTIL AGE: __________

THUMB OF FINGER SUCKING HABIT **NOW**? ☐ Y ☐ N

DOES CHILD HAVE PAIN, POPPING, GRATING, OR CLICKING NOISES IN HIS OR HER JAW JOINTS? ☐ Y ☐ N

IF YES, PLEASE EXPLAIN ____________________

IS ORTHODONTICS A NEW EXPERIENCE FOR THE PATIENT? ☐ Y ☐ N

IF NO, PLEASE EXPLAIN ____________________

HAS THE PATIENT EVER BEEN EVALUATED BY ANOTHER ORTHODONTIST? ☐ Y ☐ N

IS ORTHODONTICS A NEW EXPERIENCE FOR THE FAMILY? MOTHER, FATHER, SIBLINGS? ☐ Y ☐ N

IF NO, PLEASE EXPLAIN ____________________

DOES/DID ANYONE ELSE IN THE FAMILY HAVE CROWDED, SPACED APART, OR PROTRUDING TEETH? ☐ Y ☐ N

IF YES, PLEASE DESCRIBE ____________________

PLEASE LIST YOUR CHIEF CONCERNS & COMMENTS ABOUT YOUR CHILD'S TEETH IN THE SPACE PROVIDED BELOW.

____

____

TO YOUR KNOWLEDGE, DOES PATIENT HAVE ANY MISSING PERMANENT TEETH OR EXTRA TEETH? ☐ Y ☐ N

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT COULD BE DESCRIBED AS... ☐ FAVORABLE ☐ INDIFFERENT ☐ RESISTANT

PLEASE DESCRIBE YOUR CHILD'S TEMPERAMENT (ANY INFORMATION PROVIDED ALLOWS US TO PROVIDE THE HIGHEST LEVEL OF CUSTOMIZED CARE FOR YOUR CHILD):

____

I, ____________________, HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. IF THERE ARE ANY CHANGES TO THESE HISTORY RECORDS OR MEDICAL/DENTAL STATUS, I WILL INFORM THIS PRACTICE.

SIGNATURE: ____________________ DATE: __________

DENTAL INSURANCE INFORMATION

IS PATIENT COVERED BY DENTAL INSURANCE? ☐ Y ☐ N

IS PATIENT COVERED BY ORTHODONTIC INSURANCE? ☐ Y ☐ N ☐ UNSURE (if yes or unsure, please give your dental insurance card to the front desk)

PATIENT'S LEGAL NAME: ______________________ DATE OF BIRTH: ______________

NAME OF POLICY HOLDER: ______________________ POLICY HOLDER'S DATE OF BIRTH: ______________

POLICY HOLDER'S ADDRESS: ____
(IF DIFFERENT FROM PATIENT'S ADDRESS)
(STREET) (CITY) (STATE) (ZIP)

ID NUMBER OR SOCIAL SECURITY NUMBER: ______________________ GROUP NUMBER: ______________
(NEEDS TO BE NINE DIGITS OR MORE)

EMPLOYER/COMPANY NAME: ____

DENTAL INSURANCE COMPANY: ____

INSURANCE CO. PHONE NUMBER: ____

INSURANCE CO. ADDRESS: ____
(STREET) (CITY) **(STATE)** (ZIP)

EFFECTIVE DATE:

~ FOR OFFICE USE ONLY ~

DATE CHECKED: ______________ CHECKED BY: ______________ CONTACT PERSON: ______________

LTM: $ ______________ YEAR / LIFETIME PAID AT: ________ % DEDUCT: $ ______________

AMT USED TO DATE: ______________ AMT REMAINING TO DATE: ______________

AGE LIMIT: ______________ NEED TO PRE-AUTHORIZE? ☐ Y ☐ N

HOW IS BENEFIT PAID? MONTHLY / QUARTERLY / 2 PAY PLAN / ANNUAL / OTHER

WE BILL OR AUTO

COMMENTS: ____

WORK IN PROGRESS? ☐ Y ☐ N ELECTRONIC PAYER ID #: ______________

________ I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.
INITIALS

________ I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO DR. JAMES B. GRAY DMD, PC.
INITIALS

SIGNATURE: ______________________________ DATE: ______________