

*WELCOME TO OUR OFFICE*

[www.cgbraces.com](http://www.cgbraces.com)

Patient's full name \_\_\_\_\_ Preferred name \_\_\_\_\_ M / F Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ If Child: School \_\_\_\_\_ Grade \_\_\_\_\_ Hobbies \_\_\_\_\_

Email Address \_\_\_\_\_ Who may we thank for referring you to our office? \_\_\_\_\_

*RESPONSIBLE PARTY INFORMATION*

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Social Security# \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's Employer & Work phone # \_\_\_\_\_

Parent's Marital status if patient is child: \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Single \_\_\_

Patient Lives with: \_\_\_\_\_

In case of an emergency, closest relative or friend other than above \_\_\_\_\_ Telephone \_\_\_\_\_

*INSURANCE INFORMATION*

Subscriber's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance Company name \_\_\_\_\_ Benefit Amt \$ \_\_\_\_\_

Subscriber's SS # \_\_\_\_\_ Date of birth \_\_\_\_\_ Employer \_\_\_\_\_

*PATIENT'S DENTAL & GENERAL HEALTH*

What is the main Purpose for this visit ? \_\_\_\_\_

Who is Your Dentist ? \_\_\_\_\_ Date of patient's last dental check-up \_\_\_\_\_

Has the patient ever been evaluated for, or had orthodontic treatment before? \_\_\_\_\_

Have any other family members been examined by Dr. Cater or Dr. Galante? If yes, who? \_\_\_\_\_

YES NO Do you have allergies? If yes, type \_\_\_\_\_ Medication \_\_\_\_\_

YES NO Do you breathe through your mouth, or snore when you sleep?

YES NO Have your tonsils or adenoids been removed?

YES NO Have you ever tested positive for HIV, or ever been diagnosed with Hepatitis? Type A or B \_\_\_\_\_

YES NO Have you ever had a thumb, finger, or tongue sucking habit? If yes, how long? \_\_\_\_\_  
(TMJ), such as ; clicking in jaw, headaches, locking of jaw, clenching or grinding? \_\_\_\_\_

YES NO Are you currently under medical care for any reason? If yes please explain \_\_\_\_\_

YES NO Do you have sensitivities or allergies to metals such as nickel, copper, or titanium ? \_\_\_\_\_

AUTHORIZATION AND RELEASE: I agree to be responsible for payment of all charges, which are incidental to the care, and treatment of the above named patient with my prior consent. I authorize Dr. Cater/Galante to release any information acquired in the course of my treatment to third party payer's and/or health practitioners. I also certify the above information is correct.

RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

