Dr. Thomas Gessel
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Tacoma, WA 98465
(253) 503-1023

Thank you for selecting our orthodontic health care team! We will strive to provide you with the best possible orthodontic care. To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION – Please Print (Confidential)

Dr./Mr. Mrs./Ms. _____ Age: _____ Date of Birth: ____/____/_____
First Last M.I.

Home Address: _____ City: _____ Zip: _____ Phone: (____) _____

Business Address: _____ City: _____ Zip: _____ Phone: (____) _____

Mobile/Cell Phone: (____) _____ Email Address: _____

Person to Contact in Case of Emergency: _____ Relationship: _____ Phone: (____) _____

Name of Dentist: _____ Address: _____

How long have you been a patient at above: _____ Date of Last Dental Check-up: _____

Referred By: __Friend: _____ __Dentist __Yellow Pages __Other: _____

Your marital status: __ Single __ Married __ Widow(er) __ Divorced

Have you had any previous orthodontic treatment or orthodontic consultations? __Yes __No If yes, when? _____

If so, where? _____ What were you told? _____

What is/are your main concern(s) about your teeth? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ___ Zip: _____ Phone: (____) _____

Driver's License # : _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Employer: _____ Address: _____ Phone: (____) _____

Is this person currently a patient in our office? __Yes __No

INSURANCE INFORMATION

Do you or billing party have Orthodontic Insurance? __Yes __ No __Not Sure

If yes, Name of Insured: _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Insurance Company Carrying Policy: _____ Group#: _____ Union or Local #: _____

Name of Insured (Secondary): _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Insurance Company Carrying Policy: _____ Group#: _____ Union or Local #: _____

FAMILY INFORMATION

Children: Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Have any family members been previously treated at our offices: __Yes __No

Name: _____ Dates: _____ Office: _____

Name: _____ Dates: _____ Office: _____

Please bring your insurance information to the office at your first visit.

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone: (____) _____ Date of Last Exam: ____/____/____

	Yes	No
1. Are you under medical treatment now?	___	___
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	___	___

If yes, please explain: _____

_____

3. Are you taking any medication(s) including non-prescription medicine?	___	___
4. Have you ever taken Phen-Fen/Redux?	___	___
5. Do you use tobacco?	___	___
6. Do you use controlled substances?	___	___
7. Are you wearing contact lenses?	___	___

If yes, please list: _____

_____

8. Are you allergic to or have you had any reaction to the following:

	Yes	No
Local anesthetic (e.g. Novocaine)	___	___
Penicillin or any Antibiotics	___	___
Sulfa Drugs	___	___
Barbiturates	___	___
Sedatives	___	___
Iodine	___	___
Aspirin	___	___
Any Metals (e.g. nickel, mercury, etc.)	___	___
Latex Rubber	___	___
Other (please list): _____		

9. Women only:

a) Are you pregnant or think you may be pregnant?	___	___
b) Are you nursing?	___	___
c) Are you taking oral contraceptives?	___	___

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	___	___	Heart Disease	___	___	Chest Pains	___	___
Heart Attack	___	___	Cardiac Pacemaker	___	___	Easily Winded	___	___
Rheumatic Fever	___	___	Heart Murmur	___	___	Stroke	___	___
Swollen Ankles	___	___	Angina	___	___	Hay Fever/Allergies	___	___
Fainting/Seizures	___	___	Frequently Tired	___	___	Tuberculosis	___	___
Asthma	___	___	Anemia	___	___	Radiation Therapy	___	___
Low Blood Pressure	___	___	Emphysema	___	___	Glaucoma	___	___
Epilepsy/Convulsions	___	___	Cancer	___	___	Recent Weight Loss	___	___
Leukemia	___	___	Arthritis	___	___	Liver Disease	___	___
Diabetes	___	___	Joint Replacement or Implant	___	___	Heart Trouble	___	___
Kidney Diseases	___	___	Hepatitis/Jaundice	___	___	Respiratory Problems	___	___
Aids or HIV Infections	___	___	Sexually Transmitted Disease	___	___	Mitral Valve Prolapse	___	___
Thyroid Problem	___	___	Stomach Troubles/Ulcers	___	___	Other: _____		

PATIENT DENTAL HISTORY

Name of present dentist and location: _____ Date of Last Exam: / /

	Yes	No
1. Do your gums bleed while brushing or flossing?	___	___
2. Are your teeth sensitive to hot or cold liquids/foods?	___	___
3. Are your teeth sensitive to sweet or sour liquids/foods?	___	___
4. Do you feel pain to any teeth?	___	___
5. Have you had any sores or lumps in or near mouth?	___	___
6. Have you had any head, neck or jaw injuries?	___	___
7. Have you ever experienced any of the following	___	___
problems with your jaw:	___	___
a) Clicking	___	___
b) Pain [joint, ear, side of face]	___	___
c) Difficulty in opening or closing	___	___
d) Difficulty in chewing	___	___

	Yes	No
8. Do you have frequent headaches?	___	___
9. Do you clench or grind teeth?	___	___
10. Do you bite lips or cheeks frequently?	___	___
11. Have you ever had difficult extractions?	___	___
12. Have you ever had any prolonged bleeding?	___	___
13. Have you ever had any orthodontic treatment?	___	___
14. Do you require antibiotics for dental treatment?	___	___
15. Have you ever received oral hygiene instructions regarding care of teeth/gums?	___	___
16. Do you like your smile?	___	___

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to patient's health. I authorize Gessel Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Gessel Orthodontics any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

X _____

Signature of Patient/Responsible Party

Doctor's Comments: _____

Signature: Date: