

**Dr. Jimmy Glenos**  
Board Certified Orthodontic Specialist  
www.Smilesbyglenos.com

**Welcome to our Office**

**Our Mission is to provide the most efficient, "state of the art" orthodontic care in a warm and friendly atmosphere and to treat each and every patient as we would like to be treated ourselves.**

Patient's Name \_\_\_\_\_  
Last First Middle Preferred Name

Address \_\_\_\_\_  
Street City State Zip E-MAIL ADDRESS

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

School Name \_\_\_\_\_ Grade \_\_\_\_\_ Special Needs \_\_\_\_\_

Special Interests/Hobbies/Sports, etc \_\_\_\_\_

Siblings--Names/Ages \_\_\_\_\_

Other Family Members Treated Here / Age \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Patient Dental History**

Patient's Dentist \_\_\_\_\_

Approximate date of last cleaning \_\_\_\_\_

Current thumb or finger habit? \_\_\_\_\_

Previous Orthodontic Evaluation? \_\_\_\_\_

By Whom? \_\_\_\_\_

Orthodontic Treatment? \_\_\_\_\_

What is your MAIN concern? \_\_\_\_\_

**How would you like to be contacted for appointment reminders?**

TEXT # \_\_\_\_\_

E-MAIL \_\_\_\_\_

PHONE # \_\_\_\_\_

**Please check any of the following that the patient has currently or has a history of:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Surgical procedures     | <input type="checkbox"/> Muscle Soreness-head/neck    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Grinding teeth               |
| <input type="checkbox"/> Hearing impairment      | <input type="checkbox"/> Speech problems/Therapy | <input type="checkbox"/> Clinching teeth              |
| <input type="checkbox"/> AIDS or HIV positive    | <input type="checkbox"/> Hyperactivity           | <input type="checkbox"/> Jaw Joint Clicking           |
| <input type="checkbox"/> Tuberculosis            | Emotional problems                               | Jaw Joint popping                                     |
| <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Convulsions / Epilepsy  | <input type="checkbox"/> Jaw Joint Soreness           |
| <input type="checkbox"/> Bleeding problems       | <input type="checkbox"/> Is patient pregnant     | <input type="checkbox"/> Headaches (more than normal) |
| <input type="checkbox"/> Endocrine problems      | Ringing in ears                                  |   |

Allergies to any medications? If yes, please explain \_\_\_\_\_

Any heart problems that require premedication? \_\_\_\_\_

Any other health problems that we should be aware of? \_\_\_\_\_

Are you currently taking any medications for Bone Density? If yes please list (Fosamax, etc.) \_\_\_\_\_

# Responsible Party

Name (if different than above) \_\_\_\_\_  
Last First Middle Preferred Name  
Address (if different than above) \_\_\_\_\_  
Street City State Zip  
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Main Contact Phone # and Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_

Spouse / Other Name \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_  
Street City State Zip  
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Drivers License# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_

## Orthodontic Insurance

If you have your insurance card with you we will gladly make a copy and you will only need to complete insured's birthday and ss#:

Insurance Company \_\_\_\_\_ Policy#/Group# \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip  
Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle  
**INSURED'S BIRTHDATE** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ **Employer** \_\_\_\_\_

Do you have dual coverage?  Yes  No **IF YES, complete below:**

Insurance Company \_\_\_\_\_ Policy#/Group# \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Street City State Zip  
Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle  
Insured's Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

## In case of emergency (Other than Responsible Party)

Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Complete Address \_\_\_\_\_ Phone Number \_\_\_\_\_

## Signature

I understand the above information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in this patient's medical status. I also authorize the orthodontic staff to perform the necessary services that this patient may need. I further understand that where appropriate, credit bureau reports may be obtained.

\_\_\_\_\_  
Patient signature / Guardian signature if minor patient

\_\_\_\_\_  
Date