



Gurley, Ritter & Brogden
ORTHODONTICS

Preston Plaza
3701 NW Cary Parkway, #200
Cary, NC 27513
(919) 467-9300

Parkway Professional Park
103 Parkway Office Court, #204
Cary, NC 27518
(919) 858-0078

NEW PATIENT CONSULTATION

Today's date: _____ Patient's preferred name: _____

Patient's full name: First _____ Middle _____ Last _____

Birth Month/Day/Year: _____ Age: _____ Gender **(circle):** Male Female

Patient's street address: _____ City/State/Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

We utilize e-mail only as a way to send appointment reminders or inclement weather notifications. Please provide your preferred e-mail address: _____

Please tell us why you are seeking an orthodontic evaluation? _____

Whom may we thank for referring you to our office? _____

Patient's General Dentist: _____

When, approximately, was the last time the patient was seen by the above dentist? _____

Please **circle** any of the following for which the patient has been diagnosed or treated:

AIDS/HIV	Bone density disorder	Epilepsy or seizures	Kidney or liver disorder
Arthritis	Cancer	Fainting	Learning difference
Asthma	Diabetes	Heart or valve disorder	Prosthetic joint
Bleeding disorder	Endocrine (growth) disorder	Hepatitis	Thyroid disorder

Please elaborate for any items circled above: _____

Please add any additional medical history not covered above: _____

Please list any sensitivities or allergies (eg: drugs, latex, nickel): _____

Please list any medications the patient is currently taking: _____

Has the patient had any injuries to their teeth, mouth, or jaw? **(circle):** Yes No

If yes, please elaborate: _____

Has the patient ever needed to take antibiotics before a dental appointment? **(circle):** Yes No

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Is there any history of serious illness, accident, or operation? If yes, please explain: _____

Is the patient under the care of a physician for any issue at this time? If yes, please explain: _____

Has the patient had any previous orthodontic treatment? If yes, please elaborate including approximate date and type of treatment performed: _____

Please **circle** all that apply for the patient *currently*:

Jaw pain

Jaw popping/noises

Locked jaw

Clenching or grinding of teeth

If not current, have any of the above been issues in the *past*? If so, please elaborate: _____

Questions below pertain to a **CHILD** patient only:

Patient primarily lives with? (**circle**): Both Parents Mother Father Other: _____

Mother's name: _____ Father's name: _____ Other: _____

Parent's address (if different than patient's address): _____

Are there any other pertinent parental circumstances that may help ensure our sensitivity to your child? _____

What is your child's outlook regarding potential orthodontics? _____

Which school does your child attend? _____

Does your child currently have a thumb/finger/pacifier habit? If so, please elaborate: _____

What does your child like to do for fun? _____

Who is financially responsible for the patient? (**circle**): Mother Father Both Other

If other, please explain: _____

Who has medical authority for the patient? (**circle**): Mother Father Both Other

If other, please explain: _____

To help us best time any potential treatment, please answer the following questions:

Has your child had any recent, rapid growth? If yes, when and how much? _____

Females: Has menstruation begun? (**circle**): Yes No If yes, approximately when? _____

Printed name: _____ Signature: _____ Date: _____

Thank you!