GIBBS ORTHODONTIC ASSOCIATES, P.C.
PRACTICE LIMITED TO ORTHODONTICS

ERIC PAUL GIBBS, D.D.S.
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

FERNANDA MARCHI, D.D.S.
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

40 EAST 84TH STREET
NEW YORK, NY 10028
(212) 535-4111
FAX (212) 535-7631

Welcome to our office. Please complete this form so that we can provide the best orthodontic care for your child.

GENERAL INFORMATION

Today's Date _____/_____/_____

Patient's Full Name _____ Home Telephone ( ) _____
Address _____ Zip Code _____
Mother's Name _____ Home Telephone ( ) _____
Mother's Home Address _____ Zip Code _____
Mother Employed By _____ Bus. Telephone ( ) _____
Mother's Business Address _____ Zip Code _____
Father's Name _____ Home Telephone ( ) _____
Father's Home Address _____ Zip Code _____
Father Employed By _____ Bus. Telephone ( ) _____
Father's Business Address _____ Zip Code _____
Names and Addresses of person or persons responsible for child's account _____
_____ Zip Code _____
Name and Address of Insurance Company _____
Family Email Address _____
_____ Zip Code _____
Whom May We Thank For Referring You To Us? _____

CHILD'S HISTORY

Age _____ Date of Birth _____/_____/_____ M / F
Date of last Dental Check-up _____
Dentist's Name and Address _____ Zip Code _____
_____ Dentist's Telephone ( ) _____
List any Sports or Hobbies _____
List any Musical Instruments Played _____
School _____

MEDICAL HISTORY

Date of last Physical Examination _____
Physician's Name _____ Telephone ( ) _____
Address _____ Zip Code _____
General Health of the Patient _____
Is your child under the care of a physician at the present time and if so, for what? _____
_____
Is your child taking any medications and if so, for what? _____
Is your child ALLERGIC to any medicine, food or substance? _____
Is you child subject to prolonged bleeding? _____
Has your child ever been hospitalized? _____

Please check any of the following if your child has or has had:

Anemia _____	Asthma _____	Respiratory/Lung Disorder _____
Diabetes _____	Dizziness _____	Blood Disorders _____
Brain Injury _____	Cerebral Palsy _____	Congenital Heart Disease _____
Fainting _____	Thyroid Disorders _____	Ear Problems/Infections _____
Digestive Disorders _____	Hepatitis _____	Visual Disorders _____
Epilepsy _____	Heart Murmur _____	Convulsions/Seizures _____
Renal/Kidney Disorders _____	Measles _____	Mononucleosis _____
Mumps _____	Hives/Skin Disorders _____	Hyperactivity _____
Learning Disabilities _____	Liver Disorders _____	Coordination Disorders _____
Jaundice _____	Ulcers _____	Heart Disorders _____
Sinus Disorders _____	Rheumatic Fever _____	Rheumatoid Arthritis _____
Sickle Cell Disease _____	Transfusions _____	Tuberculosis _____
Muscle Disorders _____	Speech Problems _____	Prostheses _____
	Other _____	

Please describe the items you have checked above _____

_____

Has the child had any diseases not mentioned above _____

DENTAL HISTORY

What is the chief complaint about your child's teeth? _____

_____

Does the child have any facial pain, clicking in the jaws, or temporomandibular joint pain? _____

Does the child have any difficulties in chewing? _____

Has the child ever sucked a finger, thumb, tongue, cheek, or pacifier? _____

Is your child a tooth-grinder? _____

Have there been any injuries to the teeth, mouth or jaws? _____

Does the child ever bite the upper or lower lip? _____

Is the child a mouth breather? _____

Have you ever been informed of any missing or extra teeth? _____

Does the child have frequent canker or cold sores? _____

Is the child in need of speech therapy? _____

Has the child had a previous orthodontic examination? _____

Are the records available? _____

Because your child is a minor, it becomes necessary that permission is obtained from the parent or guardian before any and/or all necessary dental services and methods can be rendered. Accordingly, please read the following statement and sign below:

I understand that the information I provide on this form is essential to determine my child's dental needs and the provision of dental treatment. I understand that if any changes occur in my child's health, I am to report this to the office as soon as possible. Permission for necessary consultation with the patient's dentist and/or physician is hereby granted. I have read, understand each question, and have answered all of them truthfully and to the best of my ability. I have discussed my child's health history with the doctor. Furthermore, the undersigned will be responsible for any fees incurred on the above child for dental treatment rendered.

Parent or Guardian's Signature _____ Date _____/_____/_____