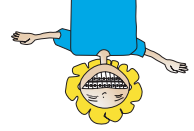




DR. GRAHAM GARDNER  
Orthodontist

Excellence in Orthodontics for Children and Adults



1206 Willow Lawn Drive  
Richmond, Virginia 23226

Phone 804.282.6436  
Email info@gardnergrins.com  
www.gardnergrins.com

# Welcome!

Please fill out the following form to help us  
give your child the best treatment possible.

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_ E-mail: \_\_\_\_\_

Ethnic Origin \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Whom can we thank for referring you to us? \_\_\_\_\_

Dentist's name: \_\_\_\_\_ Last Visited: \_\_\_\_\_

## Mother's Information

## Father's Information

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: \_\_\_\_\_

Work #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

Other family members treated here: \_\_\_\_\_

Name and age of siblings: \_\_\_\_\_

In case of **Emergency**, call: \_\_\_\_\_ Phone: \_\_\_\_\_

Any **Medical Alert** or **Allergies**: \_\_\_\_\_

Do you have any medical concerns? \_\_\_\_\_

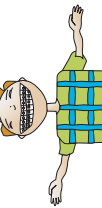
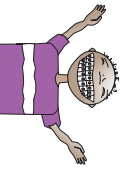
Physician's name: \_\_\_\_\_

Please list any medications that you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Are there any problems that may prohibit us from providing you with successful treatment?  
\_\_\_\_\_



(Over)



Does your child have any habits that we should be aware of? \_\_\_\_\_  
(nail biting, lip biting, tongue thrust, grinding, clenching, snoring)

Please describe your main concerns in detail that brought you to our office:

\_\_\_\_\_  
\_\_\_\_\_

Have you had any injuries to the face, mouth, or teeth? \_\_\_\_\_

\_\_\_\_\_

**Please circle the picture that you feel best represents your appearance.**



Do you feel that your concerns are more related to:

\_\_\_\_\_Cosmetics    \_\_\_\_\_Prevention    \_\_\_\_\_Function

**Financial Information:** I hereby authorize release of any information which pertains to the treatment or Insurance Benefits for the above patient. I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and have completed all of the answers. I certify this information is true and correct to the best of my knowledge.

Please sign: \_\_\_\_\_ Date: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Please complete the following information if patient is under 18 or if someone other than patient is responsible for bill:

Responsible Party's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Responsible Party's Address: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

*Thank you for your time!*