



# GUIDRY & HORAIST ORTHODONTICS

## Patient Information

Today's Date \_\_\_\_\_  Male  Female  
Name \_\_\_\_\_  
Last First MI  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Common Name \_\_\_\_\_  
Address \_\_\_\_\_  
Street City/State/Zip  
Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Email \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Email \_\_\_\_\_  
 Married  Divorced  Separated  Single  Widowed  
Spouse/Other \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Email \_\_\_\_\_  
Family members previously treated here \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## Medical/Dental History

General Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_  
Is the patient under the care of a physician for a specific reason at this time? \_\_\_\_\_  
Physician's Name \_\_\_\_\_  
Taking any prescription medication  Yes  No If so, which ones? \_\_\_\_\_  
Are you currently taking a bisphosphonate for osteoporosis?  
 Yes  No  Fosamax  Boniva  Actonel  Other \_\_\_\_\_  
List any drug sensitivities \_\_\_\_\_

### Please check all of the following that apply:

- Asthma  Jaw Joint Pain  Teeth Grinding  Diabetes  Bone Disorders  AIDS/HIV  
 Epilepsy Problems  Heart Condition  Hepatitis  ADD/ADHA  Kidney Problems  Endocrine

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Signature of Patient/Parent/Guardian

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Date