William V. Gierie, D.D.S., M.S.D.
Adult form
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What brought you to see us? Why are you here? ____________________
Referred By____________________ Date ____________________
Patient's Name____________________ Preferred Name ____________________
Birth date ____________ Age________ Sex______ Patient's Dentist____________________
Date of last dental cleaning ____________________ Date of last X-rays taken ____________
Patient SSN ____________________ Physician ____________________
Home Address____________________ Home Phone ____________________
____________________ Work Phone ____________________
Email Address____________________ Mobile Phone ____________________
Occupation ____________________ Employed By ____________________
Marital Status: Married _________ Single _________ Divorced ________ Separated ________ Widow(er) _________
Spouse's name (if applicable)____________________
Occupation ____________________ Employed By ____________________
Name of any family members we have seen ____________________
Names and Ages of Children in the family ____________________
Person(s) responsible for Payment of Account____________________
Address and Relationship to Patient (if different than above) ____________________
____

MEDICAL HISTORY

Are you in good health?____________ Do you have any history of major illness? ____________________
Please list (give dates)____________________

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

HEART TROUBLE	☐	HIV/AIDS	☐	ATTENTION DEFICIT	☐	LIVER INVOLVMENT	☐
MITRAL VALVE PRO	☐	ANEMIA	☐	KIDNEY PROBLEMS	☐	HEPATITIS	☐
HEART MURMUR	☐	EPILEPSY	☐	ENDOCRINE PROBLEMS	☐	BLOOD DISORDERS	☐
RHEUMATIC FEVER	☐	ASTHMA	☐	PROLONGED BLEEDING	☐	DIABETES	☐
PNEUMONIA	☐	FAINTING OR DIZZYNESS	☐	TUBERCULOSIS	☐	OTHER ___________	☐

Do you have a tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores ____________
Have tonsils and adenoids been removed? _____ What Age? ______ List any drugs or medications now being taken and reason. ____________________
LIST ANY ALLERGIES OR DRUG SENSITIVITY ____________________

DENTAL HISTORY

Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date ____________________
____________________ Has the patient ever sucked a thumb or fingers? **Y /N** Age ____________
Do you have any speech problems? **Y / N**
Any pain in or near the ears? **Y / N**
Have you been informed of any missing or extra permanent teeth? **Y/ N**
Has an orthodontist been consulted previously? **Y / N**
Have you ever had orthodontic treatment before? **Y / N** If yes when? ____________________
List any musical instruments played ____________________
Interests or hobbies ____________________

Signature ____________________