EDWARD M. GOLDMAN, DDS, PA
250 ENGLAR ROAD, SUITE 5
WESTMINSTER, MD. 21157

Patient Name _____Nickname_____Birthdate_____Age_____
Address_____ ___Phone _____
Street City State Zip
Father's Name_____ Employer_____ Occupation_____

Father's Address_____
Street City State Zips
Father's Home#_____Cell#_____Work#_____

Mother's Name_____ Employer_____ Work#_____
Street City State Zips
Mother's Address_____

Mother's Home#_____ _Cell#_____ _Work#_____

Dentist_____Physician_____
Whom Do We Thank For Referral? Dentist_____ Friend_____ Web Site_____ Ad_____ Other_____

Reason for seeking orthodontic treatment_____

Who will be responsible for this account_____

Do you have insurance_____ Insurance Company Name_____

Social Security # of Insured_____ Date of Birth of Insured_____

Do you have secondary insurance_____ _Insurance Company_____

Social Security # of Insured_____ Date of Birth of Insured_____

Emergency Contact _____ Phone #_____ Relationship_____
Address_____

MEDICAL HISTORY

Is patient under physician's care now?_____Current medications_____
Allergies to medications or other substances_____

Has patient ever had any of the following illnesses or condition?

Heart Disease_____	Diabetes_____	Grinding/Clenching_____
Lung Disease_____	High/Low Blood Pressure____	Clicking/Noisy Jaw_____
Rheumatic Fever_____	Cancer_____	Head/Neck Injury_____
Sore Throats_____	Convulsions_____	Injury to Head/Neck_____
Asthma_____	Fainting_____	Suck fingers/Thumb_____
Hay Fever_____	Emotional Problems_____	Hearing Problems_____
Persistent Cough_____	Depression_____	Anemia_____
Bronchitis_____	Difficulty Breathing_____	Tuberculosis_____
Hepatitis_____	Venereal Disease_____	Jaundice_____
Tonsils Removed____	Adenoids Removed_____	Immune Disorder_____

Any other conditions we should be aware of?_____
Are parents aware that some appointments will be during school hours?_____
Signature of parent/Guardian_____Date_____

DOCTOR'S FORM

Name_____ Age_____ Date_____

Profile_____Face_____Teeth_____|_____MdLn____|_____

Class_____ Overjet_____ Overbite_____Crossbite_____|____

Arch Length: Upper_____ Lower_____

Brux_____TMJ_____Caries_____

OH: E G F P

Eruption pattern _____Facial Asymmetry_____

Records_____Recall_____ Siblings in TX_____
Notes: