



2 James Street  
Auburn, NY 13021

Tel (315)252-7259  
Practice Limited to Orthodontics  
Fax (315)252-6148

**Part I - Patient Information**

Name \_\_\_\_\_  
(first) (middle) (last) (nickname)

Address \_\_\_\_\_  
(street) (town, state, zip) (e-mail)

Gender \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Siblings(with ages) \_\_\_\_\_

Hobbies and Interests \_\_\_\_\_

Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Birthdate \_\_\_\_\_

SS# \_\_\_\_\_ Flexible Spending Account \_\_\_\_\_

*(If separated)*

Parent or Guardian Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Birthdate \_\_\_\_\_

SS# \_\_\_\_\_ Flexible Spending Account \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

What are your main concerns or what would you like to find out by coming to see Dr. Gush? \_\_\_\_\_

Has there been any previous orthodontic treatment or consultation? \_\_\_\_\_

Dr. Gush has my permission to obtain diagnostic materials he deems necessary for orthodontic evaluation. I also authorize him to provide other health care providers and/or your insurance carrier with information regarding my/my child's orthodontic care if considered appropriate. I also understand it is my responsibility to keep Dr. Gush's office informed of any change in medical or dental health status.

Parent/Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_