Welcome

Date_____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you. During your examination, we may be talking to your dental insurance to determine your orthodontic benefit.

Name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ _____ Email_____

Soc. Sec. #_____Marital Status ___Single ___Married ___Separated ___Divorced ___Widowed ___Partner

Patient Employed by _____Occupation_____

Contact in case of emergency _____H Phone _____W Phone_____

Dentist _____Whom may we thank for referring you to our office_____

Responsible Party Information

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone_____ Work phone_____ Email _____

Social Security #_____ Birthdate _____ Relationship to Patient_____

Employer_____ Occupation_____

Primary Dental Insurance Information

Insured's Name_____ Insured's Social Security # _____

Relation to Patient _____ Birthday _____

Insurance Company_____ Group No._____ Subscriber No. _____

Orthodontic Benefit_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes, please fill out additional dental insurance info below:

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____Subscriber No. _____

Please complete both sides

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No to questions (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have any other allergies (latex, metals, seasonal, etc.) _____
Yes No Any history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever taken a bisphosphonate medication (i.e. Fosamax, etc.) _____
Yes No Has a doctor ever instructed you to take antibiotic premeds prior to dental treatment? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

Dentist _____ Date of last visit _____

Why are you interested in orthodontic treatment? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Are you presently in any dental pain? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have you ever had any injury to the face, mouth or teeth? _____
Yes No Do your gums bleed when you brush/floss? _____
Yes No Do you have any type of thumb or tongue or nail biting or other habit(s)? _____
Yes No Are you a mouth breather? If yes, when awake or sleeping or both _____
Yes No Have your tonsils or adenoids been removed? If yes, when _____
Yes No Do your teeth or jaws ever feel uncomfortable when awakened in the morning? _____
Yes No Are you aware of jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day/night? _____
Yes No Has anyone ever told you of grinding your teeth? _____
Yes No Do you get “tension” headaches? _____
Yes No Do you ever experienced chronic ringing in your ears? _____
Other information about your dental health or previous treatment _____
For female patients:
Yes No Are you pregnant? If yes, how many weeks? _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used to help determine appropriate healthful orthodontic treatment. If there are any changes in my medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance. In addition, I authorize Dr. Wahl to perform a complete orthodontic evaluation.

Signature: _____ Date: _____
(Parent of Guardian if patient is a minor)