PLEASE PRINT

Date..

PATIENT INFORMATION

PATIENT'S NAME...
LAST FIRST MIDDLE LIKES TO BE CALLED

ADDRESS.. CITY.. STATE.................. ZIP......................................

DATE OF BIRTH.. AGE.............. ❑ MALE ❑ FEMALE CELL PHONE .... HOME PHONE ....

SCHOOL.. GRADE.............. SPORTS / INTERESTS..

PATIENT LIVES WITH: ❑ BOTH PARENTS ❑ MOTHER ❑ FATHER ❑ GUARDIAN REFERRED BY...

PATIENT'S DENTIST.. PHYSICIAN..

RESPONSIBLE PARTY INFORMATION

NAME.. ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED
LAST FIRST MIDDLE

ADDRESS.. CITY.. STATE.................. ZIP......................................

HOW LONG AT THIS ADDRESS?.................................. HOME PHONE.. WORK PHONE..

SOCIAL SECURITY #.. DRIVER'S LICENSE #.. DATE OF BIRTH..

EMPLOYER.. OCCUPATION.. HOW LONG EMPLOYED....................

SPOUSE'S NAME...
LAST FIRST MIDDLE

SOCIAL SECURITY #.. DRIVER'S LICENSE #.. DATE OF BIRTH..

SPOUSE'S EMPLOYER.. OCCUPATION.. WORK PHONE..

INSURANCE INFORMATION

INSURED'S NAME.. INSURED'S SOCIAL SECURITY #..

INSURANCE COMPANY.. GROUP #..

INSURANCE CO. ADDRESS.. PHONE #..

DO YOU HAVE DUAL COVERAGE? ❑ YES ❑ NO If yes, please fill in below:

INSURED'S NAME.. INSURED'S SOCIAL SECURITY #..

INSURANCE COMPANY.. GROUP #..

INSURANCE CO. ADDRESS.. PHONE #..

CONTACT INFORMATION

PHONE Home..Work..Cell..

BEST TIME AND PLACE TO CONTACT YOU..

IN CASE OF EMERGENCY, PLEASE CONTACT: (Specify someone who does NOT live in your household.)

NAME.. RELATIONSHIP..

PHONE Home..Work..Cell..

MEDICAL HISTORY

HAS THE PATIENT EVER HAD:

Condition			Condition			Condition		
DIABETES	❑ YES	❑ NO	TUBERCULOSIS	❑ YES	❑ NO	ENDOCRINE/THYROID	❑ YES	❑ NO
PNEUMONIA	❑ YES	❑ NO	ANEMIA	❑ YES	❑ NO	PROLONGED BLEEDING	❑ YES	❑ NO
HEART TROUBLE	❑ YES	❑ NO	EPILEPSY	❑ YES	❑ NO	HEPATITIS	❑ YES	❑ NO
RHEUMATIC FEVER	❑ YES	❑ NO	ASTHMA	❑ YES	❑ NO	FAINTING/DIZZINESS	❑ YES	❑ NO

Do you have any other medical concerns? ❑ YES ❑ NO Explain............

Is the patient currently taking any drug or medications? ❑ YES ❑ NO Please list............

Does the patient use tobacco products? ❑ YES ❑ NO What type?............

Does the patient use any controlled substances? ❑ YES ❑ NO Please list............

Is the patient allergic to any of the following? ❑ Acrylic ❑ Nickel ❑ Latex ❑ Other............

Has the patient tested POSITIVE for HIV/AIDS? ❑ YES ❑ NO

Does the patient wear contact lenses? ❑ YES ❑ NO

Have patient's tonsils and adenoids been removed? ❑ YES ❑ NO At what age?............

Does the patient snore? ❑ YES ❑ NO

Growth in the last six months: .... Has patient reached puberty? ❑ YES ❑ NO

Height: Patient............ Mother............ Father............ Patient most resembles: ❑ MOTHER ❑ FATHER ❑ BOTH

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ❑ YES ❑ NO Explain............

Did the patient ever suck thumb, fingers, pacifier? ❑ YES ❑ NO Until what age?............

Does the patient have any problems with speech? ❑ YES ❑ NO Explain............

Does the patient play a musical instrument? ❑ YES ❑ NO What type?............

Been informed of any missing/extra permanent teeth? ❑ YES ❑ NO

Has the patient had previous orthodontic examinations? ❑ YES ❑ NO

Is the patient especially apprehensive about dental visits? ❑ YES ❑ NO

Does the patient want orthodontic treatment? ❑ YES ❑ NO

When did the patient last visit the general dentist?............ Were any x-rays taken?............

Does the patient have any congenital (born with) abnormalities?............

TMJ HISTORY

Has the patient ever had any discomfort or clicking in the jaw-joint near the ears? ❑ YES ❑ NO

Does the patient clench or grind his/her teeth? ❑ YES ❑ NO

Does the patient have frequent head or neck aches? ❑ YES ❑ NO

Does the patient have pain or ringing in the ears? ❑ YES ❑ NO

Has the patient's jaw ever locked or slipped out of place? ❑ YES ❑ NO

Are the patient's teeth sore or sensitive? ❑ YES ❑ NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Wyoming Springs Orthodontics of any changes in medical status.

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Signature of Patient, Parent, or Guardian Date