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 .....

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED REFERRED BY.....

PATIENT'S DENTIST..... PHYSICIAN.....

RESPONSIBLE PARTY INFORMATION

NAME..... (LAST / FIRST / MIDDLE) ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

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

HAVE YOU EVER HAD:

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.....

Are you currently taking any drug or medications? ❑ YES ❑ NO Please list.....

Are you currently taking Bisphosphonates? ❑ YES ❑ NO Which one?.....

Do you have arthritis? ❑ YES ❑ NO

Are you currently under the care of a physician? ❑ YES ❑ NO Why?.....

Do you use tobacco products? ❑ YES ❑ NO What type?.....

Do you use any controlled substance? ❑ YES ❑ NO Please list.....

Are you allergic to any of the following? ❑ Acrylic ❑ Nickel ❑ Latex ❑ Other.....

Have you tested POSITIVE for HIV/AIDS? ❑ YES ❑ NO

Do you wear contact lenses? ❑ YES ❑ NO

Have your tonsils and adenoids been removed? ❑ YES ❑ NO At what age?.....

DENTAL HISTORY

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

Do you play a musical instrument? ❑ YES ❑ NO What type?.....

Do you have any problems with your speech? ❑ YES ❑ NO Explain.....

Do you breathe predominantly through your mouth? ❑ YES ❑ NO

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

Have you had previous orthodontic examinations? ❑ YES ❑ NO

Have you had any periodontal treatment? ❑ YES ❑ NO

Have you had your wisdom teeth removed? ❑ YES ❑ NO At what age?.....

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

What is the reason for your orthodontic examination?.....

TMJ HISTORY

Do you have any discomfort or clicking in the jaw-joint near the ears? ❑ YES ❑ NO

Do you clench or grind your teeth? ❑ YES ❑ NO

Do you have frequent head or neck aches? ❑ YES ❑ NO

Do you have pain or ringing in the ears? ❑ YES ❑ NO

Has your jaw ever locked or slipped out of place? ❑ YES ❑ NO

Are your 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 Date