wolfe
ORTHODONTICS

Date: _____

Patient Information

Name_____, _____ (_____) Gender: ____ Date of Birth __/__/__ Age___
Last First Preferred Name month-day-year

Address_____, _____, _____
Street City Zip

Home Phone (____) ____-_____Name of Parent/Guardian (if patient is a minor) _____

Whom may we thank for referring you to our office? _____

Have you visited other orthodontists before? Yes___ No___

Responsible Party Information

Name_____, _____ Gender:____ Relationship to Patient:_____
Last First

Address_____, _____, _____ _____
Street City State Zip

Mailing Address (if different) _____, _____, _____ _____

Phone: Home(___)____-_____ Work(___)___-_____ Cell (___)____-_____ Email _____@_____

Previous Address (if less than 3 years) _____, _____, _____ _____

Social Security #_____Date of Birth _____/_____/_____ Occupation_____

Employer _____Phone (___)____-_____ #Years Employed_____

Address_____, _____, _____ _____
Street City State Zip

Spouse (if applicable) Name_____, _____Relationship to patient_____
Last First

Address_____, _____, _____ _____
Street City State Zip

Social Security #_____Date of Birth _____/____/_____ Occupation_____

Employer _____Phone (___)____-_____ #Years Employed_____

Address_____, _____, _____ _____
Street City State Zip

Insurance Company Information

Insured Name #1_____ Insured Name #2_____

Insurance Company _____ Insurance Company _____

Insurance Company Phone #_____ Insurance Company Phone #_____

Insurance Company Address _____ Insurance Company Address _____

_____ _____

Insurance Group # _____ Insurance Group # _____

We will assist you in filing insurance claims. However, your insurance policy and coverage is an arrangement between your employer and the insurance company. Therefore, insurance checks will be mailed to you rather than to our office. If an insurance payment check is mailed to us, we will endorse it and return it to you.

You may also benefit from IRS approved programs that allow the use of pre-tax income to pay for healthcare. Does your employer offer the following health savings programs?

Flexible Spending Account (FSA) Yes___ No___

Health Savings Account (HAS) Yes___ No___

Continued

In Case of Emergency, Please Notify the Following

Name_____, _____ Phone (___)____-_____ Email _____@_____
Last First

Address_____, _____, _____ _____
Street City State Zip

Patient's Name_____, _____ (_____) Gender: ____DOB ___/___/___
Last First Nickname month day year

Patient's Health Care Providers: Dentist: Dr. _____Phone (___)____-_____

Primary Physician: Dr. _____Phone (____)_____-_____

The following questions are about you, the patient. Please answer all questions.

Yes	No		Yes	No	
[ ]	[ ]	Are you in good health?	[ ]	[ ]	Is there any major illness in the past?
[ ]	[ ]	Are you allergic to penicillin?	[ ]	[ ]	Are you allergic to nickel?

Please list any medical condition that your orthodontist should know before giving you treatment.

_____

[ ] None

Health Background

Have you ever had any of the following health problems? Please answer all questions (check Yes or No).

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Allergies/Sinus	[ ]	[ ]	Frequent colds	[ ]	[ ]	Speech problems
[ ]	[ ]	Anemia	[ ]	[ ]	Glaucoma	[ ]	[ ]	Surgery
[ ]	[ ]	Arthritis	[ ]	[ ]	Heart trouble	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Asthma						
[ ]	[ ]	Autism Spectrum	[ ]	[ ]	Hepatitis	[ ]	[ ]	Thyroid
[ ]	[ ]	Bleeding problems	[ ]	[ ]	Hyperactivity	[ ]	[ ]	Tumors
[ ]	[ ]	Bone disorders	[ ]	[ ]	Immune deficiency	[ ]	[ ]	Ulcers
[ ]	[ ]	Cold sores/HSV1	[ ]	[ ]	Kidney disease	[ ]	[ ]	Any serious medical problem
[ ]	[ ]	Concussion	[ ]	[ ]	Liver problems	[ ]	[ ]	Injuries to face, mouth, teeth
[ ]	[ ]	Diabetes	[ ]	[ ]	Psychiatric Treatment	[ ]	[ ]	Ever had tonsils removed
[ ]	[ ]	Epilepsy	[ ]	[ ]	Pneumonia	[ ]	[ ]	Ever had any cancer_____
[ ]	[ ]	Fainting/Dizziness	[ ]	[ ]	Rheumatic fever	[ ]	[ ]	Snoring
[ ]	[ ]	Sleep apnea	[ ]	[ ]	Taking any medication List:_____			

Dental Information

Yes	No		Yes	No	
[ ]	[ ]	A thumb, finger or other sucking habit?	[ ]	[ ]	A habit of grinding or clenching teeth?
[ ]	[ ]	Mouth breathing?	[ ]	[ ]	Noise, pain, or locking of jaw joints?
[ ]	[ ]	Previous orthodontic examination?	[ ]	[ ]	Has any parent or sibling had braces?
[ ]	[ ]	Did teeth come in at the usual time?	[ ]	[ ]	Any missing or extra teeth?
[ ]	[ ]	Any injuries to the face, mouth, or teeth? If yes, please provide detail. _____			

_____

I certify that the information that I have given here and elsewhere to this office is complete and true to the best of my knowledge. I understand that this information will be held in strict confidence, and it is my responsibility to inform this office of any changes of the information provided (including the patient's medical status).

_____ _____
Signature of Patient (or Parent/Guardian if Patient is a minor) Date

Print Name: _____

Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named. _____ _____
Initial Date