

# MW ORTHODONTICS

We would like to get to know you better!

PLEASE MAKE SURE ALL INFORMATION IS COMPLETE

Today's Date \_\_\_\_\_

**PATIENT NAME**

(First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_  
Home Address: \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) - \_\_\_\_\_  
Sex:  Male  Female Birth date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age \_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
General Dentist: \_\_\_\_\_ Referred By: \_\_\_\_\_

Please List Any Family Members or Friends Who Are Patients in Our Office:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**SPOUSE'S NAME**

Mr.  Dr.  Rev.  \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ SS# \_\_\_\_\_

Carrier Address \_\_\_\_\_

Carrier Phone (\_\_\_\_\_) \_\_\_\_\_ Group # \_\_\_\_\_

Signature \_\_\_\_\_

**RESPONSIBLE PARTY – FOR ABOVE PATIENT – IF SAME AS ABOVE CHECK OFF HERE \_\_\_\_\_**

Name Of: \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ SS# \_\_\_\_\_

Carrier Address \_\_\_\_\_

Carrier Phone (\_\_\_\_\_) \_\_\_\_\_ Group # \_\_\_\_\_

05-9ad

# MW ORTHODONTICS

**\*\* PLEASE MAKE SURE ALL INFORMATION IS FILLED OUT BELOW – THANK YOU \*\***

<b>MEDICAL HISTORY</b>																							
<p>Please check box if patient has or has had:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Joint Swelling</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Bone Disorders</td> <td><input type="checkbox"/> Anemia</td> </tr> <tr> <td><input type="checkbox"/> Heart Trouble</td> <td><input type="checkbox"/> Asthma</td> </tr> <tr> <td><input type="checkbox"/> Rheumatic Fever</td> <td><input type="checkbox"/> Epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Thyroid Problems</td> <td><input type="checkbox"/> Prolonged Bleeding</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Faintness or Dizziness</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Tonsils Removed</td> </tr> <tr> <td><input type="checkbox"/> Emotional Problems</td> <td><input type="checkbox"/> Tonsillitis</td> </tr> <tr> <td><input type="checkbox"/> Brain Injury</td> <td><input type="checkbox"/> Adenoids Removed</td> </tr> <tr> <td><input type="checkbox"/> Kidney or Liver Involvement</td> <td><input type="checkbox"/> Sore Throats</td> </tr> <tr> <td><input type="checkbox"/> AIDS or AIDS Related Complex (ARC)</td> <td><input type="checkbox"/> Ear Aches</td> </tr> </table> <p>Please list any other serious or medical problems not listed above: _____</p> <p>Describe: _____</p> <p>List any drug allergies (penicillin dental anesthetic, aspirin, etc.): _____</p> <p>List drugs or medications now being taken: _____</p> <p>Is patient under physician's care presently? _____</p> <p>Reason: _____</p> <p>Name of Physician: _____</p> <p>Do you require antibiotic pre-medication prior to dental procedures? _____</p> <p>Have there been any past injuries to face, mouth or teeth? _____</p>	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Faintness or Dizziness	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tonsils Removed	<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Adenoids Removed	<input type="checkbox"/> Kidney or Liver Involvement	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> AIDS or AIDS Related Complex (ARC)	<input type="checkbox"/> Ear Aches	<p>Please check box if answer is <u>yes</u>:</p> <p><input type="checkbox"/> Any injuries to face, mouth, teeth? (circle)</p> <p><input type="checkbox"/> Mouth-breathing when asleep, awake? (circle)</p> <p><input type="checkbox"/> More than average amount of decay?</p> <p><input type="checkbox"/> Any missing permanent teeth?</p> <p><input type="checkbox"/> Any extra permanent teeth?</p> <p><input type="checkbox"/> Any teeth removed by extraction?</p> <p><input type="checkbox"/> Visits dentists regularly?</p> <p>Date of last dental visit: _____</p> <p>Dentist: _____</p> <p><input type="checkbox"/> Has an Orthodontist been consulted previously?</p> <p>Reason: _____</p> <p><input type="checkbox"/> Is this visit for a second opinion?</p> <p><input type="checkbox"/> Family history of under-bite? (strong lower jaw)</p> <p><input type="checkbox"/> History of thumb/ finger sucking habit?</p> <p><input type="checkbox"/> Any history of speech therapy?</p> <p><input type="checkbox"/> Any difficulty in swallowing of chewing?</p> <p><input type="checkbox"/> Any pain of clicking on opening mouth?</p> <p><input type="checkbox"/> Adopted?</p> <p>Sports: _____</p> <p>Why would you like to have orthodontic treatment accomplished? _____</p> <p>_____</p> <p>_____</p> <p>Patient's attitude having orthodontics (circle one):</p> <p align="center"> <input type="radio"/> Wants it done  <input type="radio"/> Does not want it done  <input type="radio"/> Does not care         </p>
<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Tuberculosis																						
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Anemia																						
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Asthma																						
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy																						
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Prolonged Bleeding																						
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<input type="checkbox"/> AIDS or AIDS Related Complex (ARC)	<input type="checkbox"/> Ear Aches																						

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_ Date \_\_\_\_\_