

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 (____) _____

City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____

Sex: Male Female Birth date _____ - _____ - _____ Age _____ (*School Patient Attends*): _____

E Mail Address: _____

General Dentist: _____ Referred By: _____

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

Name: _____ Relationship: _____

FATHER'S NAME

Mr. Dr. Rev. _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

SS# _____ - _____ - _____ Birthdate _____ - _____ - _____ Marital Status _____

Employer _____ Occupation _____

Work Phone (____) _____ Cell Phone (____) _____

Dental Insurance Carrier _____

Carrier Address _____

Carrier Phone (____) _____ Group # _____

Signature _____

MOTHER'S NAME

Mrs. Ms. Dr. Rev. _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

SS# _____ - _____ - _____ Birthdate _____ - _____ - _____ Marital Status _____

Employer _____ Occupation _____

Work Phone (____) _____ Cell Phone (____) _____

Dental Insurance Carrier _____

Carrier Address _____

Carrier Phone (____) _____ Group # _____

Signature _____

RESPONSIBLE PARTY FOR ABOVE PATIENT - IF SAME AS ABOVE PLEASE CHECK HERE _____

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

SS# _____ - _____ - _____ Birthdate _____ - _____ - _____ Marital Status _____

Employer _____ Occupation _____

Work Phone (____) _____ Cell Phone (____) _____

Dental Insurance Carrier _____

Carrier Address _____

Carrier Phone (____) _____ Group # _____

05-9CH

MW ORTHODONTICS

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

MEDICAL HISTORY																							
<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: _____ 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? ____ Reason: _____ 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) <input type="checkbox"/> Mouth-breathing when asleep, awake? (circle) <input type="checkbox"/> More than average amount of decay? <input type="checkbox"/> Any missing permanent teeth? <input type="checkbox"/> Any extra permanent teeth? <input type="checkbox"/> Any teeth removed by extraction? <input type="checkbox"/> Visits dentists regularly?</p> <p>Date of last dental visit: _____ 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? <input type="checkbox"/> Family history of under-bite? (strong lower jaw) <input type="checkbox"/> History of thumb/ finger sucking habit? <input type="checkbox"/> Any history of speech therapy? <input type="checkbox"/> Any difficulty in swallowing or chewing? <input type="checkbox"/> Any pain of clicking on opening mouth? <input type="checkbox"/> Adopted?</p> <p>Sports: _____ _____</p> <p>Why would you like to have orthodontic treatment accomplished? _____ _____</p> <p>Patient's attitude having orthodontics (circle one):</p> <p style="text-align: center;"> <input type="checkbox"/> Wants it done <input type="checkbox"/> Does not want it done <input type="checkbox"/> 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																						
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Faintness or Dizziness																						
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tonsils Removed																						
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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 _____