

WELCOME!

We want to welcome you and your child to our orthodontic practice. We are looking forward to an enjoyable association which will result in healthier teeth and a sensational smile. Before we begin, we ask that you fill out this form in ink as completely as you can. If you have any questions, just let us know and we will be glad to help. Please print. Thank you.

PATIENT INFORMATION

Today's Date ___/___/___ Patient Number (provided by office) _____
 Patient's Full Name _____ Nickname, if any _____
 Age _____ Birthdate ___/___/___ Gender M / F SS# _____ - _____ - _____ Phone _____
 Street Address _____ City _____ State _____ Zip _____
 School Attending _____ Grade _____ Hobbies/Interests _____

PARENT/RESPONSIBLE PARTY INFORMATION

Who is financially responsible for account? _____ Relationship to patient? _____
 Who is responsible for making appointments? _____ Relationship to patient? _____
 Please list patient's siblings and their ages _____
 Whom may we thank for referring you to us? _____
 Parents' Marital Status Single Married Separated Divorced Widowed
 Father/Guardian's Name _____ Mother/Guardian's Name _____
 Father Stepfather Guardian Other _____ Mother Stepmother Guardian Other _____
 Address (if different from patient's) _____ Address (if different from patient's) _____
 Home Phone _____ Work Phone _____ Home Phone _____ Work Phone _____
 Social Security No. _____ Birthdate ___/___/___ Social Security No. _____ Birthdate ___/___/___
 Drivers License No. _____ Drivers License No. _____
 Employer & Occupation _____ Employer & Occupation _____

INSURANCE INFORMATION

Do you have dental/orthodontic insurance? Yes No If yes, Insurance Company _____
 Insured's Name _____ Insurance Company Address _____
 Insured's relationship to patient _____ Insurance Company Phone _____
 Insured's Birthday ___/___/___ Group and/or Policy No. _____
 Insured's Social Security Number _____ - _____ - _____ Do you have secondary orthodontic insurance? Yes No
 Insured's Employer _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency and you can't be reached, whom should we contact?
 Name _____ Relationship to patient _____ Phone _____
 Name _____ Relationship to patient _____ Phone _____

PATIENT MEDICAL HISTORY

Physician's Name _____ Office Phone _____ Date of Last Exam ___/___/___ Results _____

How would you describe patient's current health? Excellent Good Fair Poor

Is patient currently under a doctor's care? Yes No If yes, for what? _____

Is patient currently taking any medications (even non-prescription)? Yes No If yes, what are they? _____

Has patient ever been hospitalized for surgery or serious illness? Yes No If yes, please describe _____

Is patient allergic to any drugs that you are aware of? Yes No If yes, please list _____

Has puberty begun? Yes No Has menstruation begun (girls)? Yes No

Has patient had a history of or difficulty with any of the following? Please check all that apply.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Other _____ |

PATIENT DENTAL HISTORY

Dentist's Name _____ Office Phone _____ Date of Last Visit ___/___/___ Results _____

How often does patient visit the dentist? Every six months Once a year Other _____

Does patient brush daily? Yes No Floss regularly? Yes No How often? _____

Has patient ever had an unfavorable reaction from previous dental care? Yes No If yes, please explain _____

Has patient been evaluated for or had orthodontic treatment before? Yes No If yes, please describe _____

Who recommended seeking orthodontic treatment? Decided on own Dentist Hygienist Physician Other _____

What are the primary concerns and final objectives expected from orthodontic treatment? _____

Has patient ever experienced injuries to the face, mouth, teeth, jaw, or chin? Yes No If yes, please explain _____

Does patient have any pain/tenderness in jaw joint? Yes No If yes, please describe _____

Has patient ever been informed of any missing or extra permanent teeth? Yes No If yes, please explain _____

Has patient has adenoids or tonsils removed? Yes No If yes, please indicate when _____

Does patient play any musical instruments by mouth? Yes No If yes, what are they? _____

Please indicate which of the following apply to patient by checking the appropriate boxes.

<input type="checkbox"/> Tongue Thrust	<input type="checkbox"/> Speech Problems	<input type="checkbox"/> Thumb/Finger Sucking
<input type="checkbox"/> Mouth Breather	<input type="checkbox"/> Nail Biting	<input type="checkbox"/> Lip Biting/Sucking
		<input type="checkbox"/> Clenching/Grinding Teeth

AUTHORIZATION AND RELEASE

I verify that the information given is accurate to the best of my knowledge. I understand that it will be held in the strictest of confidence, and I realize that it is my responsibility to inform the office of any changes in the medical status of this patient. I also authorize Dr. Willes and his staff to perform any necessary dental services my child/dependant may need.

Signature of Parent/Guardian _____ *Date* ___/___/___

I authorize my insurance company to pay Dr. Michael G. Willes, D.D.S., all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. Finally, I authorize Dr. Willes to release all information necessary to secure the payment of benefits.

Signature of Parent/Guardian _____ *Date* ___/___/___