walkoworthodontics

Date

Patient Information

First Name
Middle Initial
Last Name
Nick Name
Gender
Age
Birthday
Address
City
Social Security
State
Zip
Spouse's Name
Years at current address
Spouse's Phone
Email
Home Phone
How did you hear about us?
Business Phone
Mobile
School
Grade

Responsible Party Information

First Name
Middle Initial
Last Name
Birthday
Please check here if info is same as above
Social Security
Address
City
Relationship to patient
State
Zip
Occupation
Email
Employer
Home Phone
Years at current employer
Business Phone
Mobile

Orthodontic Insurance Information

Please check here if info is same as above ☐

Insured's Name

Address

City

State

Zip

Insured's SS #

Birthday

Insurance Company

Group Number

Local Number

If you have dual insurance coverage please fill out the area below

Insured's Name

Address

City

State

Zip

Insured's SS #

Birthday

Insurance Company

Group Number

Local Number

Medical History

Are you in good Health?

Physician | Physician Phone

Do you have a history of any major illness?

Are you now, or could you be pregnant?

Have tonsils and adenoids been removed? What age?

Do you have a tendency for colds or sore throats?

Do you have trouble sleeping or snore when you sleep?

Do you require premedication for dental procedures

Are you taking any medicine?

List any allergies or sensitivities: (drugs, latex, metal...)

Please check any of the following that you have had or currently have:

- ☐ Arthritis
- ☐ Asthma or Hayfever
- ☐ Blood Disorders
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Problems
- ☐ Hepatitis/Liver Problems
- ☐ Herpes
- ☐ HIV/Aids
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

Dental History

Dentist Name

Date of Last Visit

Please check any of the following which apply to you, and add any relevant comments.

What are your primary concerns?

Have you been informed of any missing or extra permanent teeth?

Have there been any injuries to your head, face, mouth or teeth?

Have you ever sucked your thumb or finger?

Do you have any speech problems?

Do you have a tongue thrust habit?

Are you a mouth breather?

Do you clench or grind your teeth?

Do you use a mouth guard or plastic splint?

Have you ever had orthodontic treatment or consulted an orthodontist for treatment?

If yes, who?

And when?

Do you know or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?

Are you interested in Invisalign as a treatment option?

By typing my initials in the box here I confirm that the information I have given above to the best of my knowledge is accurate and will be held in the strictest of confidence. It is my responsibility to inform the office of any changes in my medical status. I also understand that if necessary a credit report may be obtained.

Print

Email

Signature____________________________ Date__________________________