Crist & Wenande Orthodontics, Prof. L.L.C.

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Please completely fill out all of the information on this form. Please sign the form where indicated and bring it with you to your first appointment. Thank you!

Patient Information

Date______________ Nick Name____

Patient's Name ____ Patient lives with: ☐ Mother ☐ Father ☐ Both ☐ Guardian

First Middle Last

Address____

Street City State Zip

Home Phone__________________________Birthday______________________Age________Sex_________

School____Grade_________________

If patient is a minor, give parent or guardian's name____

Whom may we thank for referring you to our office_______________________Dentist______________

Name of relatives treated here_____________________________________Relation___________________

Responsible Party Information

Primary ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ___________

Responsible Party______________________________________Telephone_____________________________

Address____How Long_____________________________

Employer/Address____Telephone__________________

Social Security Number________________________________Birthday_______________________________

Secondary ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ___________

Responsible Party_________________________________Telephone_________________________

Address____How Long_________________________

Employer/Address____Telephone________________

Social Security Number____________________________Birthday___________________________

Insurance Information (please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance_________________________Telephone________________

Address____

Street City State Zip

Name of Policy Holder_________________ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other_______

Policy Holder's Birthdate________________

Name of Secondary Orthodontic Insurance_________________________Telephone______________

Address____

Street City State Zip

Name of Policy Holder_________________ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other_______

Policy Holder's Birthdate________________

Emergency Information (name of nearest relative not living with you)

Name_____________________________________Relation_________________________

Phone Number________________________Comments____________________________________

Reason for evaluation- Your primary concern

____

____

Date of most recent dental exam_____________How often do you brush_________Floss________

For the following questions circle yes, no or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

yes no dk/u Birth defects or heredity problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u Hepatitis, jaundice or liver problems?
yes no dk/u AIDS or HIV positive?
yes no dk/u Sexually transmitted diseases?
yes no dk/u Fainting spells, seizures, epilepsy or neurologic disease?
yes no dk/u Mental health or behavioral problems?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Easily tired?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary, insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart)?
yes no dk/u Skin disorder?
yes no dk/u Do you have a normal and good diet?
yes no dk/u Frequent headaches, cold or sore throats?
yes no dk/u Any history of speech problems?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hay fever, asthma, sinus trouble, hives?
yes no dk/u Tonsils/Adenoids removed? Age:______
yes no dk/u Allergies or drug reactions?
yes no dk/u Are you taking medication, nutrient supplements or nonprescription medicine? Please name them.
____
yes no dk/u Do you currently have or ever had a substance abuse problem?
yes no dk/u Operations?__________When?___________
yes no dk/u Hospitalization? For___________________________
yes no dk/u Other physical problems or symptoms?
yes no dk/u Being treated by another health care professional? For________________Name_____________________
yes no dk/u Are you in good health? Date of most recent physical exam______________________________
Name of Primary Physician______________________

Dental History

yes no dk/u Chipped or otherwise injured permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u "Dead Teeth" root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "Gum Problems"
yes no dk/u "Gum Boils" frequent canker sores, cold sores?
yes no dk/u Thumb, finger, sucking habit? Until________
yes no dk/u Abnormal swallowing habit (tongue thrust)?
yes no dk/u Mouth breathing habit, snoring, difficulty breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Experience any pain or soreness in the muscles of your face or around your ears?
yes no dk/u Any pain in jaw or ringing in ears?
yes no dk/u Been treated for TMJ problems (jaw joint or facial pain) ?
yes no dk/u Difficulty encountered in chewing or jaw opening?
yes no dk/u History of supernumerary (extra) or congenitally missing teeth?
yes no dk/u Have any permanent teeth been removed?
yes no dk/u Aware of loose, broken or missing restorations?
yes no dk/u Any teeth irritating, cheek, lip, tongue, palate?
yes no dk/u Ever had orthodontic treatment or worn a bite plate or retainer?
yes no dk/u Are you seeking a second opinion from us?
yes no dk/u Ever had Periodontal (gum) treatment?
yes no dk/u Concerned about space, crooked, protruding teeth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Any relative with similar tooth or jaw relationships?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Have you had any serious trouble associated with any previous dental treatment?

Female Patient

yes no dk/u Are you pregnant?
yes no dk/u Are you taking birth control pills?
yes no dk/u Are you anticipating becoming pregnant?
yes no dk/u Have you started menstruating?

I have read and understand the above questions, I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form AND If there are any changes later to the personal information or the medical/dental status, I will inform this practice AND I understand that I am responsible for payment for any service/treatment provided. I further understand that my credit reports may be obtained prior to Crist & Wenande Orthodontics, Prof. L.L.C. extending me credit for any service/treatment.

Signature (parent if a minor)____Date__________________