New Patient Information and Medical Dental History Form

wirthlin orthodontics
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Patient Information

Patient's Name: _____ _____ _____ Sex: ☐ M ☐ F
First MI Last

Preferred name: _____ Birth Date: _____ Age: _____

Address: _____ _____
Street City, State, ZIP

Home Phone: _____ Cell Phone: _____

Email: _____

Appointment reminders will be sent via email and text. Please check here if you would NOT like to receive these types of reminders ☐

How did you hear about our office? Who can we thank for the referral? _____

Personal Information (Child)

School: _____ Grade: _____

Brothers/Sisters (ages): _____

Responsible Party Information

Name: _____ _____ _____ Birth Date: _____
First MI Last

Address (if different): _____ _____
Street City, State, ZIP

Relationship to Patient: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer: _____ Occupation: _____

Main Phone: _____ Work Phone: _____ Cell Phone:_____

Email Address: _____

Spouse's Name: _____ _____ _____ Birth Date: _____
First MI Last

Relationship to Patient: _____ Email Address: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Dental Insurance Information

Primary Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone #: _____

Policy Owner's Name: _____ Birth Date: _____

Relationship to Patient: _____

Do you have dual coverage? ☐ Yes ☐ No If yes, complete below:

Secondary Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone #: _____

Policy Owner's Name: _____ Birth Date: _____

Relationship to Patient: _____

Medical History

Physician: _____ Date of Last Visit: _____

Please check Yes or No (If Yes, please list details)

Y N

☐ ☐ Is the patient in good health? _____

☐ ☐ Is the patient taking any medications? Please list: _____

☐ ☐ Is the patient allergic to any medication? Please list: _____

☐ ☐ Has the patient ever been involved in a serious accident? Explain: _____

☐ ☐ Have you taken any medication for osteoporosis in the past? Please list: _____

Does the patient have or has he/she had any of the following diseases or conditions? (Check Yes or No)

Y	N		Y	N		Y	N	
☐	☐	Abnormal bleeding/Hemophilia	☐	☐	Heart Defect, murmur, disease	☐	☐	Nervous Disorders
☐	☐	Arthritis	☐	☐	Hepatitis (if yes, circle A B C)	☐	☐	Radiation/Chemotherapy
☐	☐	Asthma	☐	☐	Herpes/Fever Blisters	☐	☐	Rheumatic Fever
☐	☐	Bone Disorders	☐	☐	High or low Blood Pressure	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	HIV/AIDS	☐	☐	Tumor or Cancer
☐	☐	Fainting or Dizziness	☐	☐	Joint Replacement or Implant	☐	☐	Tonsils/Adenoids removed
☐	☐	Epilepsy	☐	☐	Latex or Nickel Allergy/Sensitivity			

Are there any medical conditions, diseases or problems not discussed that you feel we should be aware of?

_____

Dental History

General Dentist: _____ Date of Last Visit: _____

What are the main concerns you would like to address: _____

Patient's attitude towards orthodontic treatment: ☐ Very Motivated ☐ Will Cooperate (if needed) ☐ Not Motivated

Y N

☐ ☐ Is the patient experiencing any dental problems/pain? _____

☐ ☐ Have there been any injuries to: (select all that apply) ☐ Face ☐ Mouth ☐ Teeth

☐ ☐ Has an orthodontist been consulted previously? Reason: _____

☐ ☐ Are you aware that some appointments will be during school/work hours?

Does the patient have or has he/she had any of the following diseases or conditions? (Check Yes or No)

Y	N		Y	N		Y	N	
☐	☐	Tongue Thrust habit	☐	☐	Missing Permanent Teeth	☐	☐	Permanent Tooth extraction
☐	☐	Finger/Thumb sucking	☐	☐	Extra Permanent Teeth	☐	☐	Fear of Dental Work
☐	☐	Fingernail biting	☐	☐	Jaw Pain (TMJ/TMD)	☐	☐	Clenching/Grinding
☐	☐	Mouth breather	☐	☐	Jaw Joint clicking/popping	☐	☐	Previous Orthodontic Therapy

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I acknowledge that the above information is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform Dr. Wirthlin of any changes that occur after this date. I hereby authorize Dr. Wirthlin and his team to take x-rays and perform a complete orthodontic evaluation/examination. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

I hereby acknowledge that I have read and discussed, if necessary, the above history with patient/parent/guardian.