WINNING SMILES
ORTHODONTICS FOUNDATION

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PATIENT NAME_____ Common Name_____
Hobbies/Sports/Musical Instruments_____
Date of **BIRTH** _____/_____/_____Age _____ Male (_____) Female (_____)
Responsible Party_____ Relationship to Patient_____
Address_____Zip Code_____
Phone #: Home (_____)_____-_____ Work (_____)_____-_____ Cell(_____)_____-_____

Would you like us to text, e-mail, and/or call with your appointment reminders? TEXT EMAIL CALL
E-Mail Address _____@_____.____
Additional E-Mail Address _____@_____.____
Cell Phone # *(for text)*(_____)_____-_____ Phone # *(for calls)* (_____)_____-_____

If patient is a Minor please continue – Adult patients may skip down to the Insurance Information if any or the Dental History
Mothers Name _____ Phone #(_____)_____-_____
Single □ Married □ Divorced □Deceased (If Applicable) Stepfathers Name _____
Address if different from above_____
Employer _____Occupation _____
Fathers Name _____ Phone #(_____)_____-_____
Single □ Married □ Divorced □Deceased (If Applicable) Stepmothers Name _____
Address if different from above_____
Employer _____Occupation _____

How did you hear about us? _____
Name of Person(s)-(other than parents) who may be accompanying the patient for the appointments:
_____Relationship to Patient _____
What information are we able to give to this person: NONE FINANCIAL TREATMENT ANY *(circle one)*

ORTHODONTIC INSURANCE INFORMATION
(Only needed if there is orthodontic coverage)

Primary Insurance *Orthodontic Coverage? YES/NO*
Name of Insured_____ Relationship to Patient_____
Birth date_____/_____/_____ SS#_____-_____-_____ Employers Phone # (_____) _____-_____
Name of Employer_____ Insurance Company_____
Group # _____ Policy#_____
Address_____ Phone # (_____) _____-_____

Secondary Insurance *Orthodontic Coverage? YES/NO*
Name of Insured_____ Relationship to Patient_____
Birth date_____/_____/_____ SS#_____-_____-_____ Employers Phone # (_____) _____-_____
Name of Employer_____ Insurance Company_____
Group # _____ Policy#_____
Address_____ Phone # (_____) _____-_____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my/my child's medical/personal status. I also authorize the dental staff to perform the necessary dental services I/my child may need during treatment.

_____/_____/_____
Signature (Patient or Parent/Guardian) **Date**

DENTAL HISTORY

Name of Dentist_____ Phone # (_____)_____-_____
Address_____ Date of last Cleaning_____/_____/_____
What are your main concerns you would like the orthodontist to accomplish? _____
_____

Y/N – Clenching/Grinding
Y/N – Thumb/Finger Sucking
Y/N – Nursing/Bottle/Pacifier Habits
Y/N – Do you still have you wisdom teeth
Y/N – Have you ever taken Fosamax or any other bisphosphonate
Y/N – Has your child been evaluated or had orthodontic care before
Y/N – Are you aware of any missing or extra permanent teeth
Y/N – Have there been any injuries to the face, mouth, teeth or chin
Y/N – Has there even been any pain/tenderness in the jaw joint (TMJ/TMD)
Y/N – Lip Sucking/Biting
Y/N – Tongue Thrust
Y/N – Do you floss daily
Y/N – Do you brush daily
Y/N – Mouth Breather
Y/N – Nail Biting
Y/N – Speech Problems
Y/N – Any Tobacco Use
Y/N – Ever taken Phen-Fen

MEDICAL HISTORY

Name of personal physician_____ Phone # (_____)_____-_____
Date of last visit_____/_____/_____ Your current physical health is: Good □ Fair □ Poor □
Have Adenoids/Tonsils been removed? Y/N Has Puberty Begun? Y/N Girls-Has Mensruation Begun? Y/N
Please list any medications/drugs you are taking:_____
Any medical conditions we should be aware of: _____

Have you had any of the following diseases or medical problems?

Y/N – Abdominal Bleeding/Hemophilia
Y/N – ADD/ADHD
Y/N – AIDS/HIV+
Y/N – Alcohol/Drug Abuse
Y/N – Anemia
Y/N – Any Hospital Stays/Operations
Y/N – Arthritis
Y/N – Artificial Bones/Joints/Valves
Y/N – Asthma
Y/N – Blood Transfusion
Y/N – Cancer/Chemotherapy/Radiation
Y/N – Colitus/Ulcers
Y/N – Congenital Heart Defect
Y/N – Diabetes
Y/N – Difficulty Breathing
Y/N – Emphysema
Y/N – Epilepsy/Seizures/Fainting
Y/N – Frequent Headaches
Y/N – Glaucoma
Y/N – Handicaps/Disabilities
Y/N – Hay Fever
Y/N – Hearing Impairment
Y/N – Heart Attack/Surgery
Y/N – Heart Murmur
Y/N – Hepatitis
Y/N – Herpes/Fever Blisters
Y/N – High/Low Blood Pressure
Y/N – Kidney/Liver Problems
Y/N – Lupus
Y/N – Mitral Valve Prolapse
Y/N – Psychiatric Problems
Y/N – Rheumatic Problems
Y/N – Scarlet Fever
Y/N – Shingles
Y/N – Sickle Cell Disease/Traits
Y/N – Sinus Problems
Y/N – Stroke
Y/N – Tuberculosis
Y/N – Venereal Disease
Y/N – Other(please explain)
_____
_____

Are you allergic to any of the following?

Y/N – Aspirin Y/N – Codeine Y/N – Latex Y/N – Penicillin
Y/N – Dental Anesthetic Y/N – Tetracycline Y/N – Plastics Y/N – Erythomycin
Y/N – Any Type of Metal/Nickel _____Y/N – Other (please explain) _____

For Women Only

Y/N – Are you Pregnant (Week#: _____) Y/N – Are you Nursing Y/N – Are you taking Birth Control

_____ _____/_____/_____
Signature (Patient or Parent/Guardian) **Date**

_____ _____/_____/_____
Signature (Orthodontist) **Date**