Welcome to WB Orthodontics, PLLC

Date_____________ **Reason for today's visit** ____

Patient's name (Last, First M) __________________________________**Social Security #**______-______-______

Date of Birth: _______ **Age**: ____ **Race:** _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow

Guardian's name (Mom) (Last, First) ____

Guardian's name (Dad) (Last, First) ____

Pt. Height:

Pt. Weight:

Guardian's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Address _______________________________________City______________________________Zip________________

Occupation____________________ #Years_______ Home#______________________ Cell #______________________

Employer_____________________________Address________________________________Work #________________

Patient extras:

Nickname_________________________School____________________________Sport/Hobby____________________

Whom may we thank for referring you to our office? ____

☐ Website ☐ Sign ☐ Mailer ☐ Newspaper/Magazine ☐ Radio ☐ Internet Site

Dental Insurance Information (Insurer)

Insured's Name _________________________ SS #____-____-____ Relationship to patient____________________

Insurance Co.__________________________Group#________________Local#_________________________________

Date of Birth____________________ Employer_______________________ Work #____________________________

Secondary Insurance (if any)

Insured's Name_________________________ SS#____-____-____ Relationship to patient____________________

Insurance Co.__________________________Group#________________Local#________________________________

Date of Birth____________________ Employer_______________________ Work #____________________________

Medical History of patient:

Physician ____Date of last Visit________________________

Address____Phone____________________________________

Have you been in a hospital during the past 2 years_______ When/Where? __________________________________

Have you been involved in a serious accident/major operation? ____

Medications____

Any Allergies: ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Aspirin ☐ Other_________________________

☐ Seasonal ☐ Food____________________________

Female Patient: Are you pregnant? ___________________________ Nursing? ______________________

Female Patient 18 and under: Has menstruation started? ___________ What age? ______________

<u>Male/Female</u> Under 18: Height of mother _______________Height of Father______________

Change in clothes or shoe size in the last 6 months? ___Y ___N

Are you aware that some of your dental appointments will be during school hours? ___Y___N

Check any of the medical conditions below that patient has had or currently has:

__Abnormal Bleeding/Hemophilia	__Diabetes	__Hepatitis	__Pneumonia
__Anemia	__Arthritis	__Asthma	__Bone Disorder
__Congenital Heart Defect	__Epilepsy/Seizure	__Heart Murmur	__Heart Problem
__Kidney Problem	___Radiation	__Tuberculosis	__Tumor/Cancer
__Radiation/Chemotherapy	___HIV/AIDS	__Sinus Problems	__High Blood Pressure

Any other medical condition/disability we should know about? _______________________________________

Have you had facial trauma recently or in the past? ____

<u>Dental History of patient</u>

General Dentist________________________________ City ______________Date of last visit_______________

Are your teeth sensitive to hot/cold/pressure____ Where? ____

Have you ever seen an orthodontist? If yes, who and when? ____

Dental Habits or Problems Currently/ in the past: (Please circle all that apply)

__ Grind/Clench __ Thumb/finger sucking __ Jaw Joint Pain/Popping/Clicking __ Nail biting __ Cheek biting

__ Lip biting __Chewing on pens/pencils/ice __ Mouth breather __Tongue habit/Lisp Other _____________

<u>Benefits</u>

Benefits of Orthodontics: Aesthetics, health, and function. Orthodontics is a service that provides and improvement in the appearance of teeth, and general health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition I authorized **<u>Dr.Wakeshi Benson</u>** to perform a complete orthodontic evaluation.

Signature of Patient or legal guardian____Date_______________

Help us Go Green!!!!! Please provide an email address ____

Please list name(s) of any person(s) that are **<u>authorized</u>** to bring in patient for Orthodontic appointments:

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