Welcome to Wilson Orthodontics

Information provided is confidential and will become part of you dental record.

PERSONAL INFORMATION

Title, First, Last Name: [ ] Male [ ] Female

Preferred Name: Birthdate: Age:

Mailing Address: City: State & Zip Code:

Home Phone: Work Phone: Cell Phone:

Email: Employer: Occupation:

Who noticed an orthodontic concern?: [ ] You/Family [ ] Dentist Other:

What are your orthodontic concerns?

How did you hear about us?

[ ] My Dentist	Name:	[ ] Internet search:
[ ] My Hygienist	Name:	[ ] Newspaper, which one:
[ ] My coworker/friend/neighbor	Name:	[ ] Radio ad:
[ ] Your staff member referred me	Name:	[ ] Other. Please explain:

FAMILY INFORMATION

Spouse's Name (if applicable): Preferred Name:

Sons (with ages):

Daughters (with ages):

Have any family members received orthodontic treatment? [ ] Yes [ ] No If yes, please name:

DENTAL HISTORY

General dentist: Date of last cleaning: Date of last X-rays:

Is there any pending dental work? [ ] Yes [ ] No

If yes, please explain:

Have you ever been evaluated for, or previously had, orthodontic treatment?

Have there been any injuries to the mouth, teeth, face or chin? If yes, describe injury and indicate when trauma occurred.

Have you ever been seen by or referred to a periodontist? [ ] Yes [ ] No Name of periodontist:

Have you ever had periodontal surgery (gum graft, bone graft, deep cleaning, implants etc.)?

Check an of the following dental issues which apply:

[ ] Clenching teeth	[ ] Mouthbreathing	[ ] Muscle soreness around head & neck	
[ ] Grinding teeth	[ ] Jaw joint clicking	[ ] Wearing night guard	[ ] Nail biting
[ ] Jaw joint pain (TMJ)	[ ] Jaw joint popping	[ ] History of jaw locking	[ ] Snoring

Speech problems or tongue thrusting? [ ] Yes [ ] No

If yes, please elaborate:

Have you ever worn a nighttime flexible or rigid mouthguard or splint [ ] Yes [ ] No

If yes, why?

MEDICAL HISTORY

Physician: Date of last exam:

Are you in good Health? [ ] Yes [ ] No Are you currently under a physician's care? [ ] Yes [ ] No

Tobacco Use (smoking; chewing)? [ ] Yes [ ] No Do you need to premedicate for dental visits? [ ] Yes [ ] No

Women only: Are you pregnant or anticipate becoming pregnant? [ ] Yes [ ] No

Check any of the following which apply:

[ ] Heart murmur/Disease	[ ] HIV+/AIDS	[ ] Kidney Disease	[ ] Cold sores
[ ] Blood disorder/Anemia	[ ] Hepatitis	[ ] Rheumatic fever	[ ] Migraines/Frequent Headaches
[ ] Bone disorders/Osteoporosis	[ ] Tuberculosis (TB)	[ ] Arthritis	[ ] Allergies
[ ] Diabetes	[ ] Convulsions/Epilepsy	[ ] Asthma	[ ] Sinus trouble
[ ] Cancer	[ ] Psychological/Emotional Issues	Other:	

Please provide additional information on any above checked medical issues or any other conditions:

Please list any drugs/medications you are currently taking:

Are you currently taking or have previously taken Fosamax or bone restoring medications/ [ ] Yes [ ] No if so, for how long?

Are you allergic to any medicines, acrylic, latex, metals, or local anesthesia (Novocaine or Lidocaine)? If yes, please specify.

DENTAL INSURANCE INFORMATION

Primary Insurance Company Name:

Subscriber's Name: Date of Birth:

Subscriber's Employer: Group #:

Subscriber's Plan ID#: Social Security # if no Subscriber Plan #:

Secondary Insurance Company Name:

Subscriber's Name: Date of Birth:

Subscriber's Employer: Group #:

Subscriber's Plan ID#: Social Security # if no Subscriber Plan #:

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my medical/dental status or personal information.

Signature

Date