Welcome to Wilson Orthodontics

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

PATIENT INFORMATION

Child's First Name: Last Name: [ ] Male [ ] Female

Nickname: Home Phone:

Mailing Address: City: State & Zip Code:

Child's Email Address: Child's Cell Phone:

How did you hear about us (check all that apply):

[ ] 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:

School: Grade: Birthdate: Age:

Hobbies/Sports/Interests:

Brothers: Sisters:

Who is accompany this child today: Relationship to patient:

Does this person have legal custody of the child? [ ] Yes [ ] No

THE PARENT(S)/GUARDIAN(S) WITH WHOM THIS PATIENT RESIDES:

Parents: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Partnered [ ] Widowed

Title, First, Last Name: Relationship to Patient:

Email: Home Phone:

Cell Phone: Work Phone:

Occupation: Employer:

Title, First, Last Name: Relationship to Patient:

Email: Home Phone:

Cell Phone: Work Phone:

Occupation: Employer:

IF APPLICABLE, INFORMATION OF OTHER PARENTS/GUARDIANS:

Parents: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Partnered [ ] Widowed

Title, First, Last Name: Relationship to Patient:

Mailing Address: City: State & Zip Code:

Preferred Phone: Email:

Occupation: Employer:

Title, First, Last Name: Relationship to Patient:

Mailing Address: City: State & Zip Code:

Preferred Phone: Email:

Occupation: Employer:

IF BIOLOGICAL PARENTS DO NOT RESIDE TOGETHER, SHOULD EACH PARENT RECEIVE CORRESPONDENCE? [ ] Yes [ ] No

DENTAL HISTORY

Child's general dentist: Date of last cleaning: Pending dental work? [ ]Yes [ ]No

What are your chief orthodontic concerns?:

Has your child ever been evaluated for, or previously had, orthodontic treatment?

Has your child ever had a tooth extracted? [ ] Yes [ ] No Name of dentist or oral surgeon who preformed extraction:

What is your child's anxiety level during a dental appointment Please check, 1=none to 5=very high [ ] 1 [ ] 2 [ ] 3 [ ]4 [ ] 5

If you checked 3 or greater, please explain:

Have any family members received orthodontic treatment? [ ] Yes [ ] No

If yes, please name:

Have any relatives been treated in our office [ ] Yes [ ] No Please list the names from above that have been treated in our office:

Does your child have to premedicate for dental visits? [ ] Yes [ ] No

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

MEDICAL HISTORY

Child's Physician: Date of last exam:

Is your child in good health? [ ] Yes [ ] No

Check any of the following which apply to your child:

[ ] Heart murmur/Disease	[ ] HIV+/AIDS	[ ] Allergies	[ ] Nail biting
[ ] Bleeding disorder	[ ] Hepatitis	[ ] Sinus trouble	[ ] Speech Therapy
[ ] Bone disorder	[ ] Tuberculosis (TB)	[ ] Snoring	[ ] Clicking/Popping of jaw
[ ] Diabetes	[ ] Cold sores	[ ] Asthma	[ ] Jaw joint pain (TMJ)
[ ] Convulsions/Epilepsy	[ ] Jaundice	[ ] Tongue thrust	[ ] Locking of jaw
[ ] Asperger's	[ ] Rheumatic fever	[ ] Lip sucking/Biting	[ ] Clenching/Grinding teeth
[ ] ADHD	[ ] Migraines	[ ] Mouth breather	[ ] Arthritis
[ ] Cancer	Other:		

Does your child have a history of thumb or finger sucking? [ ] Yes [ ] No If yes, until what approximate age?

Have the tonsils and/or adenoids been removed? [ ] Yes [ ] No

Has your child reached puberty? (Girls: started menstruation; Boys: voice changes) [ ] Yes [ ] No [ ] Soon If yes at what age?

Please list any medication/drugs your child is currently taking.

Is your child allergic to any medicines, acrylic, latex, metals, or local anesthesia (Novocaine or Lidocaine)? If yes, please specify:

Please provide additional information on any above checked medical issues or any other conditions we should be aware of.

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 child's medical/dental status or personal information.

Signature

Date