



Orthodontics for Children and Adults

Don L. Wilson, DDS, MSD

**Confidential Patient Information**

First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Last Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ School/Employer: \_\_\_\_\_

Who May We Thank for Referring you to our office: \_\_\_\_\_  
Please list the names of any friends or family currently in our practice: \_\_\_\_\_

Please list any sports, hobbies, or musical instruments played: \_\_\_\_\_  
We love to connect with our patients on Facebook. Are you on Facebook?  YES

Male  Female  Single  Married  Divorced

Patient and Responsible Party are the same (complete information below)

**Responsible Party Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ E-mail: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ No of Yrs. Employed: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Primary Insurance Information**

Do you have insurance that covers orthodontic treatment?  YES  NOT SURE (complete information below)  NO

Insurance Co. Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_ Social Security # \_\_\_\_\_

Subscriber's ID Number: \_\_\_\_\_ Group #: \_\_\_\_\_

(Please turn over to complete remaining information)

**Secondary Insurance Information**

Insurance Co. Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Employer of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Subscriber's ID Number: \_\_\_\_\_ Group #: \_\_\_\_\_

**Emergency Information**

Name of Nearest Relative Not Living With You: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Medical History			Patient Dental History	
Doctor's Name:	Date of Last Visit:		Dentist's Name:	Date of Last Visit:
YES NO		COMMENTS	YES NO	
<input type="checkbox"/> <input type="checkbox"/>		Current medications? _____	<input type="checkbox"/> <input type="checkbox"/>	Are you apprehensive about dental visits?
<input type="checkbox"/> <input type="checkbox"/>		Fainting or dizzy spells? _____	<input type="checkbox"/> <input type="checkbox"/>	Injuries to face, jaw, mouth, or teeth?
<input type="checkbox"/> <input type="checkbox"/>		Presently under a doctor's care? _____	<input type="checkbox"/> <input type="checkbox"/>	Any speech problems/therapy?
<input type="checkbox"/> <input type="checkbox"/>		Pregnant? _____	<input type="checkbox"/> <input type="checkbox"/>	Mouth breather?
<input type="checkbox"/> <input type="checkbox"/>		Frequent headaches? _____	<input type="checkbox"/> <input type="checkbox"/>	Snore during sleep?
<input type="checkbox"/> <input type="checkbox"/>		Tonsils or adenoids been removed? _____	<input type="checkbox"/> <input type="checkbox"/>	Grind or clench teeth?
Have you been diagnosed or treated for any of the following? (check as appropriate, note comments below)			<input type="checkbox"/> <input type="checkbox"/>	Pain, tenderness or noise in jaw?
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/>	Bleeding during brushing or flossing?
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> <input type="checkbox"/>	Brush and floss teeth daily?
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> <input type="checkbox"/>	Discomfort from teeth or gums?
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> <input type="checkbox"/>	Frequently chew gum?
<input type="checkbox"/> Bone Problems	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Concerned about the appearance of your teeth?
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/>	Any missing or extra permanent teeth?
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	Have you previously had orthodontics?
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Tumor/Cancer	Orthodontist	
Comments on Medical History: _____ _____ _____ _____			Name: _____	
			<input type="checkbox"/> <input type="checkbox"/> Have other family members had orthodontics? Who? _____ <input type="checkbox"/> <input type="checkbox"/> Are there any other dental/orthodontic problems Dr. Wilson should be aware of? _____ _____	

I understand that the information provided is correct to the best of my knowledge. This information will be held in the strictest of confidence and it is my responsibility to inform this office of changes to any information or the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that the patient may need. I understand that I am responsible for the payment of services rendered.

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT**

I acknowledge that I have received your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_