Weller ORTHODONTICS

David R. Weller DDS, MS
Specialist in Orthodontics

Welcome to our office! Please tell us about yourself!

Patient Information

Patient's Name _____ Preferred name _____
First Middle Last

Birth date _____/_____/_____ Age_____ ❑ Male ❑ Female School _____

SSN _____ Names and ages of siblings _____

Address _____
Street apt # City/State/Zip

Hobbies _____ Whom may we thank for referring you to our office? _____

Home Ph# (_____)_____ Cell Ph# (_____)_____ Wk Ph# (_____)_____X_____

E-mail Address _____

Responsible Party Information

Name_____ Birth date _____ SSN _____
First **Last**

Relation to Patient_____ Employer _____ Occupation _____ Number yrs employed _____

Address _____ # yrs at this address _____

Home Ph# (_____)_____ Cell Ph# (_____)_____ Wk Ph# (_____)_____X_____

Name_____ Birth date _____ SSN _____
First **Last**

Relation to Patient_____ Employer _____ Occupation _____ Number yrs employed _____

Address _____ # yrs at this address _____

Home Ph# (_____)_____ Cell Ph# (_____)_____ Wk Ph# (_____)_____X_____

Insurance Information

Does the patient have orthodontic insurance coverage? YES NO If yes:

Insured's Name_____ SSN _____ Birth date ____/_____/_____

Employer _____ Insurance Company_____ Ins. Phone #_____ Group# _____

Does the patient have secondary coverage? (circle one) YES NO If yes:

Insured's Name_____ SSN _____ Birth date ____/_____/_____

Employer _____ Insurance Company_____ Ins. Phone #_____ Group# _____

Emergency Information

Emergency contact _____ Relation _____ Phone _____

Address _____

Medical History

Has the patient ever experienced any of the following medical problems:		
Abnormal Bleeding/ Hemophilia	YES	NO
Anemia	YES	NO
AIDS/HIV+	YES	NO
Artificial joints/bones/valves	YES	NO
Asthma	YES	NO
Arthritis	YES	NO
Bone Disorders/Osteoporosis	YES	NO
Cancer/Tumor/Chemotherapy/Radiation	YES	NO
Cold Sores/fever blisters	YES	NO
Congenital heart defect	YES	NO
Diabetes	YES	NO
Dizziness	YES	NO
Epilepsy/seizures/fainting	YES	NO
Heart Attack/ stroke/ surgery	YES	NO
Heart Murmer	YES	NO
Hepatitis/Liver problems	YES	NO
Herpes	YES	NO
High/Low Blood Pressure	YES	NO
Kidney Problems	YES	NO
Mitral Valve Prolapse	YES	NO
Nervous Disorders	YES	NO
Rheumatic/ Scarlet Fever	YES	NO
Severe/frequent headaches	YES	NO
Sickle Cell disease/ traits	YES	NO
Sinus Problems	YES	NO
Tuberculosis (TB)	YES	NO

Are you currently under the care of a physician? YES NO

Physician's Name _____ Phone _____

Practice Name_____ Last visit_____

Has the patient reached puberty? YES NO

For Female patients only: Has menstruation started? YES NO
Are you pregnant/nursing? YES NO

Are there any medical conditions not listed that we should be aware of?

_____

Please list any medication the patient is taking and what it is for:

_____

_____

_____

Are you aware of any allergies the patient may have? Please list:

_____

Patient Dental History

General/Family Dentist_____ Approximate date of last visit _____

What is the main concern that you would like orthodontics to accomplish? _____

Has patient ever been evaluated for orthodontic treatment? YES NO *If yes: When?* _____ *Where?* _____

Has the patient ever been told he/she had to take an **antibiotic** prior to dental work? YES NO

Do your gums ever bleed when you brush? YES NO

Does/has the patient ever experienced any of the following: (circle all that apply)

Clenching or Grinding teeth *Lip Sucking/Biting* *Mouth Breathing (day or night)* *Speech Problems/speech therapy* *Nail Biting*
Mouth/Chin/Teeth Injury *Tongue Thrust* *Thumb or Finger Sucking(after age 3)* *Pacifier Use(after age 3)* *Tobacco Use*
Missing/Extra Permanent Teeth *TMJ/Jaw Joint discomfort or popping* *Other Mouth Habit:* _____

If patient is under the age of 16: Mom's height _____ Dad's height _____

Has anyone in your family had orthodontic treatment? YES NO Who? _____

Benefits and Consent

I understand that diagnostic records may be used for professional consultation, education and research purposes.

_____
Initials

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize David R. Weller, DDS, MS, PLLC to perform a complete orthodontic evaluation.

_____ _____
Signature Date