HORIZON ORTHODONTICS

Welcome to our office! Please tell us about yourself!

Patient Information

Patient's Name _____ Preferred/Nick-Name _____

Birth date _____ Age_____ ❑ Male ❑ Female School _____ Grade_____

Names and ages of siblings _____ Hobbies _____

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

We will send email and/or text message appointment reminders:

Email address: _____

_____

Cell phone numbers for texts:

(_____)_____

(_____)_____

Responsible Party Information – Adult Patient or Parent/Legal Guardian of Minors

Name_____ Birth date _____ SSN _____
First Middle Last

Relation to Patient_____ Employer _____ Occupation _____ Yrs employed_____

Home Address _____ *City/State/Zip*_____

Years at this address _____ Own ☐ Rent ☐ Previous Address (if less than 3 years at current address) _____

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

Name_____ Birth date _____ SSN _____
First Middle Last

Relation to Patient_____ Employer _____ Occupation _____ Yrs employed_____

Home Address _____ *City/State/Zip*_____

Years at this address _____ Own ☐ Rent ☐ Previous Address (if less than 3 years at current address) _____

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

Insurance Information

*Does the patient have **dental**, orthodontic insurance coverage? (not medical plan)* YES NO UNSURE *(we can check for you)*

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

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

Does the patient have secondary coverage?

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

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

Emergency Contact Information

Emergency contact _____ Relation _____ Phone _____

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 Murmur	YES	NO
Hepatitis/Liver problems	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

Approximate date of last dental cleaning visit: _____ Any dental work still to be completed? YES NO

Main concern that you would like orthodontics to fix? _____

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

Has the patient ever been told by a doctor that he/she had to take an **antibiotic** before any dental work or cleanings? 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 (photos, models and x-rays) may be used for professional consultation, education and research purposes.
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. I understand that where appropriate, credit bureau reports may be obtained but will not affect my credit score in any way.

_____ _____
Responsible Party Signature Date

Bring this form with you to your complementary exam appointment!