WOODS ORTHODONTICS

Wayne Woods D.D.S., M.S. PLLC

WELCOME TO OUR OFFICE

ADULT PATIENT INFORMATION

Patient's Name:_____ Prefer to be called:_____ Sex:___

Home Address: _____ City:_____Zip:_____

Home Phone:_____ Age:_____ Birthdate:_____

Patient's Dentist: _____

Do you know a patient currently in our practice? If so, whom:_____

Who noticed orthodontic problem? ☐ You ☐ Patient ☐ Dentist ☐ other_____

Describe your orthodontic problem in your own words:_____

What concerns you most about orthodontic treatment:

☐ appearance in appliances ☐ cost ☐ length of time ☐ discomfort ☐ other_____

Occupation: _____

Employer:_____ Address:_____ Wk. Phone:_____

How long with this employer?_____

Who may we thank for referring you to our office?_____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name: _____ Employer:_____ Wk. Phone:_____

Person responsible for account:_____

if other than self or spouse:

Name:_____ Occupation:_____

Address:_____ City:_____ Zip:_____

In case of emergency, please provide name, address and phone number of your nearest relative:

Name:_____ Address:_____ Phone:_____

INSURANCE INFORMATION

Although we do not accept assignment of insurance benefits, we will gladly assist you in submitting your forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee):_____ Date of Birth:_____

Name of insurance company:_____ Group #:_____

Name of insured (Employee):_____ Date of Birth:_____

Name of insurance company:_____ Group #:_____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name:_____ Address:_____ Phone:_____

Have you experienced any health problems? ☐ No ☐ Yes Explain: _____

Any major change in health recently? ☐ No ☐ Yes Explain: _____

Are you currently under a physician's care? ☐ No ☐ Yes Explain: _____

Are you currently taking any medications? ☐ No ☐ Yes Explain: _____

Are you allergic to any medications? ☐ No ☐ Yes Explain: _____

Have you received a blood transfusion? ☐ No ☐ Yes Explain: _____

Have your tonsils or adenoids been removed? ☐ No ☐ Yes Explain: _____

Have you been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check if you have had any of the following conditions:

Heart Murmur..... ☐ No ☐ Yes	Hepatitis..... ☐ No ☐ Yes	Emotional Problems ☐ No ☐ Yes
Heart Surgery..... ☐ No ☐ Yes	Diabetes..... ☐ No ☐ Yes	Frequent Headaches ☐ No ☐ Yes
Rheumatic Fever..... ☐ No ☐ Yes	Kidney Disease..... ☐ No ☐ Yes	Nervous/Anxious..... ☐ No ☐ Yes
Endocrine Disorders.. ☐ No ☐ Yes	Liver Disease..... ☐ No ☐ Yes	Cancer..... ☐ No ☐ Yes
Prolonged Bleeding... ☐ No ☐ Yes	Tuberculosis..... ☐ No ☐ Yes	Bone Disorders..... ☐ No ☐ Yes
Anemia..... ☐ No ☐ Yes	Bronchitis..... ☐ No ☐ Yes	Growth Disorders..... ☐ No ☐ Yes
Blood Disease..... ☐ No ☐ Yes	Asthma..... ☐ No ☐ Yes	Mouth Breather..... ☐ No ☐ Yes
Developmental Disorder ☐ No ☐ Yes	Epilepsy..... ☐ No ☐ Yes	Herpes (Fever Blisters) ☐ No ☐ Yes
Hives/Rash..... ☐ No ☐ Yes	Fainting..... ☐ No ☐ Yes	Tonsillitis..... ☐ No ☐ Yes

Are there any other conditions or problems that you think we should know about? _____

_____

Comments: _____

_____

DENTAL HISTORY

Dentist's Name:_____ Address: _____ Phone:_____

Dental Specialist's Name:_____ Address: _____ Phone:_____

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ Only if problem exists ☐ Never Date of last visit:

Is there any unfinished care to be completed with your dentist? ☐ No ☐ Yes Explain:_____

Are you frightened about dental care? ☐ No ☐ Yes Explain:_____

Have you had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain:_____

Have you had any facial or dental injuries? ☐ No ☐ Yes Explain:_____

Do you play any musical instruments? ☐ No ☐ Yes Explain:_____

Have you consulted an orthodontist previously? ☐ No ☐ Yes Explain:_____

Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes Explain:_____

Have you had previous orthodontic treatment? ☐ No ☐ Yes Explain:_____

Are you satisfied with prior treatment? ☐ No ☐ Yes Explain:_____

Any changes in your bite or dental alignment recently? ☐ No ☐ Yes Explain:_____

What are the chief concerns you have related to the position of your teeth/bite:

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability

Please elaborate:_____

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

☐ Wear or fractures of teeth ☐ Difficulty with cleaning as related to alignment of teeth

☐ Bone or gum tissue loss ☐ Jaw joint or muscle tightness/discomfort

☐ Alignment of teeth prior to restorative dental work (crowns, Bridges, Etc.)

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head & neck ☐ Jaw joint soreness ☐ Jaw joint Popping

☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears

☐ Speech problems (if so, which sounds)_____) ☐ Mouth breathing: Awake ____Asleep ____

Is there any other information which may be helpful?_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR UPDATING ANY CHANGES OR ADDITIONS TO THIS INFORMATION IN THE FUTURE. I CONSENT TO A FINANCIAL REPORT.

_____ *Reviewed by:*_____

Patient Signature Date