WOODS ORTHODONTICS

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

WELCOME TO OUR OFFICE

CHILD PATIENT INFORMATION

Patient's Name:____________________ Prefer to be called:__________ Sex: ___

Home Address: ____________________ City: __________ Zip: ________

Patient resides with: ☐ Mother ☐ Father ☐Both ☐ Other ____________________

Home Phone:\` ______________ Age:________ Birthdate:______________

School: ______________________________ Grade ______

Patient's Dentist: ______________________________

Please describe your child's problem in your own words: ____________________

____

Patient's interests: ______________________________

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

PATIENT AND ACCOUNT INFORMATION

Parent's Marital Status: ☐ Married ☐Separated ☐ Divorced ☐ Widowed

	FATHER	MOTHER
Name:		
Address (if different from above):		
Social Security Number:		
Employer's Name:		
Business Address:		
Business Phone:		
Occupation:		
How long with employer:		
Person responsible for account:		

If other than parent:

Name:______________ Address: ____________________ Phone: ________

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: ________

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

MEDICAL HISTORY

Physician's Name:________________ Address:________________ Phone:__________

Has your child experienced any health problems? ☐ No ☐ Yes Explain:__________
Any major change in your child's health recently? ☐ No ☐ Yes Explain:__________
Is your child currently under a physician's care? ☐ No ☐ Yes Explain:__________
Is your child currently taking any medications? ☐ No ☐ Yes Explain:__________
Is your child allergic to any medications? ☐ No ☐ Yes Explain:__________
Has your child received a blood transfusion? ☐ No ☐ Yes Explain:__________
Has your child's tonsils or adenoids been removed? ☐ No ☐ Yes Explain:__________
Has your child been in a risk group for AIDS? ☐ No ☐ Yes Explain:__________

Please check if your child has 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:__________

Growth information for Patients Under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has your son or daughter reached puberty?.............................. ☐ No ☐ Yes
Girls - Has she started menstruation?...................................... ☐ No ☐ Yes When?__________
Boys - Has his voice changed?.. ☐ No ☐ Yes When?__________
Father's Height Mother's Height Adopted?....... ☐ No ☐ Yes
Names and birthdays of patient's brothers and sisters:
Have either siblings or parents had orthodontic treatment?.......... ☐ No ☐ Yes With whom:

Dentist'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 child's dentist? ☐ No ☐ Yes Explain:__________
Is your child frightened about dental care? ☐ No ☐ Yes Explain:__________
Has your child had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain:__________
Has your child had any facial or dental injuries? ☐ No ☐ Yes Explain:__________
Is there any history of thumb or finger sucking? ☐ No ☐ Yes Explain:__________
Does your child play any musical instruments? ☐ No ☐ Yes Explain:__________
Has your child consulted an orthodontist previously? ☐ No ☐ Yes Explain:__________
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes Explain:__________
Has your child 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:__________

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*