Patient Information

Wyatt Orthodontics

Date _____
MM DD YYYY

Patient's Name _____ Preferred Nick Name _____
Last First Middle

Date of Birth _____ Male ☐ Female ☐ School _____ Grade _____
MM DD YYYY

Preferred Phone _____ C ☐ H ☐ W ☐ Email _____
Cell Home Work

Residence _____
Address Suite/Apt City State ZIP

If Patient is a Minor, Name of Legal Guardian _____ Relationship to Patient _____

Whom may we thank for referring you? _____ Family Members Seen by Us _____

Responsible Party (self, spouse, parent, legal guardian)

Name _____ Relationship to Patient _____
Last First Middle

Date of Birth _____ Male ☐ Female ☐ SS# _____ Marital Status _____
MM DD YYYY

Residence _____
(If different than above) Address Suite/Apt City State ZIP

Email _____ Home # _____ Work # _____ Cell # _____

Employer _____ Address _____

Other Responsible Party (spouse, parent, legal guardian)

Name _____ Relationship to Patient _____
Last First Middle

Date of Birth _____ Male ☐ Female ☐ SS# _____ Marital Status _____
MM DD YYYY

Residence _____
(If different than above) Address Suite/Apt City State ZIP

Email _____ Home # _____ Work # _____ Cell # _____

Employer _____ Address _____

Insurance

Primary Insurance Company _____ Member # _____ Group # _____

Phone # _____ Address _____

Insured's Name _____ Relationship to Patient _____
Last First Middle

If not given above: Date of Birth _____ SS# _____ Employer _____

Secondary Insurance Company _____ Member # _____ Group # _____

Phone # _____ Address _____

Insured's Name _____ Relationship to Patient _____
Last First Middle

If not given above: Date of Birth _____ SS# _____ Employer _____

Dental History

What about your smile are you excited to change? _____

Dentist _____ Phone # _____ Address _____

Date of Last Visit _____ Reason _____ Current Dental Health Excellent☐ Good☐ Fair☐ Poor☐

List Any Needed Dental Work _____

Difficulties Associated with Dental Work	Yes ☐	No ☐
Currently in Pain	Yes ☐	No ☐
Jaw Joint Pain	Yes ☐	No ☐
Jaw Joint Popping/Clicking	Yes ☐	No ☐
Finger or Thumb Sucking	Yes ☐	No ☐
Gums Bleed when Brushing or Flossing	Yes ☐	No ☐
Wisdom Teeth Extracted	Yes ☐	No ☐
Previous Orthodontic Treatment	Yes ☐	No ☐
Taken Bisphosphonates such as Fosamax	Yes ☐	No ☐

How many times per day does patient brush? _____ On a scale of 1 to 10, how well does patient brush? _____

How many times per week does patient floss? _____ On a scale of 1 to 10, how well does patient floss? _____

Medical History

Physician _____ Phone # _____ Address _____

Latex Allergy	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Penicillin Allergy	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Allergic to Other Medications	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
AIDS or HIV Positive	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Pregnant	Yes ☐	No ☐	Excessive Bleeding	Yes ☐	No ☐
Taking Birth Control Pills	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Nervous Problems	Yes ☐	No ☐	Herpes	Yes ☐	No ☐
Heart Problems	Yes ☐	No ☐	Hypoglycemia	Yes ☐	No ☐
Low Blood Pressure	Yes ☐	No ☐	Hypo or Hyperthyroidism	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Mumps	Yes ☐	No ☐
Taking Blood Pressure Medication	Yes ☐	No ☐	Measles	Yes ☐	No ☐
Antibiotics Req'd Due to Heart	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Radiation Treatments	Yes ☐	No ☐	Scarlet Fever	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐	Sinus Problems	Yes ☐	No ☐
Taking Osteoporosis Medicine	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
			Venereal Disease	Yes ☐	No ☐

List Any Other Allergies _____

List Any Other Medications Currently Taking _____

Other Medical History _____

Emergency Contact Name _____ Phone # _____

The information on the front and back of this form is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in information including my dental and medical status. I authorize the staff at Wyatt Orthodontics to perform the necessary dental/orthodontic services my child may need.

_____ _____

Signature of Responsible Party Date