



Weddle

ORTHODONTICS

DMD, MS

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1. Please enter the patient information.

Patient First Name:	Middle Initials:	Patient Last Name:	Patient Date of Birth:
Gender:	Marital Status:		
☐ Female ☐ Male	☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed		
Street Address:	Apt./Unit #:	City:	State: Zip Code:
Mobile Phone:	Home Phone:	Work Phone:	
Email:	Preferred contact method:		
	☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email		

2. Primary Insurance

Primary *DENTAL* Insurance Company	Primary Insurance Company Telephone #
Member ID / Policy #	Group Number
Client Relationship to Insured	
☐ Self ☐ Spouse ☐ Child ☐ Other	

Insured Name	Insured Phone #	Insured Date of Birth	Insured Gender ☐ Female ☐ Male
Insured Street Address	Insured City	Insured State	Zip Code

3. SECONDARY *DENTAL* INSURANCE INFORMATION

Insured Name:	DOB:		
Employer Name:			
Insurance Company:	Phone #:		
ID#/SS#:	Group #:		
Insurance Co. Address:	City:	State:	Zip:

4. RESPONSIBLE PARTY INFORMATION

Name:	Birth Date:	
Social Security #:	Relationship to Patient	
Employer:	Occupation:	# Years Employed:

5. Spouse's Name:	Relationship to Patient:	Spouse's Birth Date:	
Spouse's Employer:	Occupation:		
# Years Employed:	Spouse's Social Security #		
Previous Address:	City:	State:	Zip:

CREDIT REPORT AUTHORIZATION I understand that a credit bureau report may be obtained if an orthodontic financial plan is requested.

Signature	Date
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6. EMERGENCY INFORMATION

Contact Person in case of emergency:

Phone

Relationship to Patient

Complete Address:

City:

State:

Zip:

7. PATIENT MEDICAL HISTORY

Patient's Name:

School Name (if minor):

Name and ages of children and siblings:

Patient Nickname

PREVIOUS CONDITIONS

8. CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- | | | |
|--|---|---|
| ☐ Anemia | ☐ Asthma | ☐ Hepatitis |
| ☐ Tonsillitis | ☐ Endocrine Problems | ☐ Excessive |
| ☐ Heart Problems | ☐ Sinus Problems | ☐ Drug Addiction |
| ☐ Bleeding | ☐ Rheumatic Fever | ☐ Diabetes |
| ☐ Nervous Disorders | ☐ Pain in Jaw Joints | ☐ Cold Sores or Fever Blisters |
| ☐ HIV Positive (AIDS) | ☐ Tuberculosis | ☐ Mitral Valve Prolapse |
| ☐ Prosthetic (Artificial) Joint | ☐ Artificial Heart Valve | ☐ Radiation/Chemo Therapy for Cancer |

9. Does the patient gag easily?

- ☐ Yes ☐ No

10. Does the patient have frequent ear infections?

- ☐ Yes ☐ No

11. Have tonsils and/or adenoids been removed?

- ☐ Yes ☐ No

12. At what age?

13. Women: Are you pregnant?

- ☐ Yes ☐ No

14. Are medications now being taken?

☐ Yes

☐ No

15. Please list type and reason:

	Type	Reason
1		
2		
3		

16. Does the patient have any allergies?

☐ Yes

☐ No

17. If yes, please list (foods, medications, environmental):

PATIENT DENTAL HISTORY

18. Dentist's Name:

Approximate date of last dental exam :

19. Have there ever been any injuries to the face, mouth, or teeth?

☐ Yes

☐ No

20. If yes, please explain:

21. Has the patient ever sucked their fingers or thumb?

☐ Yes

☐ No

22. Until what age?

23. Does patient have any speech problems?

☐ Yes

☐ No

24. Does the patient snore?

☐ Yes

☐ No

25. Is patient a mouth breather while awake?

☐ Yes

☐ No

26. Have you been informed on any extra/missing permanent teeth?

☐ Yes

☐ No

27. Has patient ever had a previous orthodontic exam?

☐ Yes

☐ No

28. Have any family members had orthodontic treatment?

☐ Yes

☐ No

29. Is there pain in the jaw joints?

☐ Yes

☐ No

If YES, When did this begin?

30. Is there any popping or cracking of the jaw joint?

☐ Yes

☐ No

If YES, When did this begin?

31. Does patient clench or grind teeth?

☐ Yes

☐ No

If YES, When did this begin?

32. Does patient have headaches?

☐ Yes

☐ No

33. What's Important to you?

	1-Not	2-Somewhat	3 - Important	4 - Very	5 - Extremely
Length of Tx					
Latest Tech					
Comfort					
Clear / Invisible					
Low Monthly Payment					
Low Down Payment					
Quality of Tx					

34. Additional Things that are important to the patient:

35. Tell us about the patient. (Sports, hobbies, interests)

36. Who can we thank for referring you to our office?

Name of General Dentist, Family Friend, Google, etc...
