Date:_______________

White Rock Orthodontics

PATIENT INFORMATION

Patient Name:____________________________Birth Date:_________________________Age:__________
Address:__________________________City:________________State:_________Zip:________________
Home Phone:_____________________________Cell Phone:_________________________SS#________________
Email address:________________________________School:__________________________Grade:________
Patient's Dentist:______________________________Would you like a referral to a dentist? Y N
Brothers' Names (ages):____________________________Sisters' Names (ages):______________________________
How did you hear about our office?____

RESPONSIBLE PARTY INFORMATION

Name:____SS#_______________________DOB:________________
Address:_________________________________City:________________State:_________Zip:__________
Email address:__________________________________Relationship to Patient:_____________________________
Home Ph: _________________________Work Ph: _________________________Cell Ph:____________________
Employer:______________________________________Occupation:____________________________________
Driver's License:___________________State:__________
Spouse Name:_______________Email address:____________________________Cell Ph:______________
Spouse's Employer:_________________________Occupation:_________________Work Ph: __________________

If patient is a minor of divorced parents, does the Responsible Party have the legal right to consent to the child's dental care?
☐Yes ☐No ☐N /A
If parents are divorced, does the other spouse have the legal right to consent to the child's dental care and have access to health records?
☐Yes ☐No ☐N /A
Name of spouse:___________________________

INSURANCE INFORMATION

Primary Policy Holder
Name:__________________________________DOB:______________________SS#:____________________
Insurance Company:________________________Policy# ____________________Group# ___________________
Insurance Company Address:__________________________City:________________State:_________Zip:__________
Insurance Company Phone: _________________________Insured's Employer:_______________________________

Secondary Policy Holder
Name:__________________________________DOB:______________________SS#:____________________
Insurance Company:________________________Policy# ____________________Group# ___________________
Insurance Company Address:__________________________City:________________State:_________Zip:__________
Insurance Company Phone: _________________________Insured's Employer:_______________________________

EMERGENCY INFORMATION

Emergency Contact (other than guardian):____
Relationship to patient:_______________Daytime Ph.:________________Alternative Ph:____________________
I certify that all of the above information is true and it is my responsibility to inform this office of any changes.
Signature (Guardian's signature if patient is a minor):_________________________________Date:_______________

(OVER)

MEDICAL HISTORY

Patient Name: ________________________________ **Vital Signs:** / **Pulse:**

Physician____ Date of Last Visit _______________________________
Address____ Phone _____________________________________
Please circle Yes or No (If Yes, please fill in details)
Yes No Are you taking any medication?____

Date:___________________

Yes No Are you allergic to any medication? ____
Yes No Have you had a major illness?____
Yes No Any surgeries?____
Yes No Do you have diabetes?____
Yes No Smoked or chewed tobacco?_____________How much?_________________When did you quit?___________
Yes No Seen a physician in the last 12 months? Why?____
Yes No Are you pregnant?____
Yes No Tonsils or adenoids removed?____
Yes No Have you ever been told by your physician to take antibiotics before your dental appointments? For what?____________

Please circle any of the medical conditions below that the patient has had or currently has:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions that we have not listed that you feel we should be aware of? ____________________________

Dr. Ortega Has Reviewed:_____

DENTAL HISTORY

General Dentist ______________________________ Date of last visit ______________________________
Address______________________________ Phone: ______________________________
Have you ever been told that you have periodontal (gum) disease?__________________What treatment did you have?_____________________
What concerns you most about your teeth or smile? ____
Please circle any of the dental conditions below that the patient has had or currently has:

Dental pain	Wisdom teeth removed	Lost or chipped teeth
Injuries to the face, mouth, or teeth	Teeth sensitive to temperature or pressure	Sore or bleeding gums
Thumb or finger sucking habit	Tongue thrust	Speech problems
Mouth breathing	Pain, clicking, popping or locking in your jaws	Clenching or grinding of teeth
Missing permanent teeth	Extra permanent teeth	Frequent headaches
Chronic ringing in the ears	Snoring or Sleep Apnea	Tender or sore jaw muscles

Yes No Have you ever seen an orthodontist? If yes, who and when? ______________________________
Yes No Has anyone in your family received orthodontic treatment? ______________________________
How did they feel about the result?______________________________
Yes No Do your teeth or jaws ever feel uncomfortable when you wake in the morning? ______________________________

Dr. Ortega Has Reviewed:_____

Signature (Guardian's signature if patient is a minor):____Date:___________

Medical Updates

1)____
DATE GUARDIAN NAME GUARDIAN SIGNATURE UPDATE? Dr. Ortega
2)____
DATE GUARDIAN NAME GUARDIAN SIGNATURE UPDATE? Dr. Ortega
3)____
DATE GUARDIAN NAME GUARDIAN SIGNATURE UPDATE? Dr. Ortega