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)

Date:_____

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?_____
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

SLEEP Screening: Sleep Apnea Snoring Mouth Breathing ADD or ADHD Headaches Restless Sleep Bedwetting
Sleep Walking Frequent Nightmares Rarely Remembers Dreams Tooth Clenching/Grinding Picky Eater Tender Jaw Muscles
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
Pain, clicking, popping or locking in your jaws	Missing permanent teeth	Extra permanent teeth

Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in your family received orthodontic treatment?_____

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