DAVID J. WEED, DDS, MSD

Specialist in Orthodontics

WELCOME TO OUR OFFICE

*So that we might become better acquainted, please complete **BOTH** sides of this form.*

ADULT PATIENT INFORMATION

Patient's Name: _____ (LAST / FIRST / MIDDLE) Prefer To Be Called: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Birthdate: _____ Age: _____

How long at this address? _____ Previous Address: (If less than 3 years) _____ (STREET / CITY/STATE/ZIP)

Patient's Dentist: _____ Referred By: _____

Do you know a patient currently in our practice? If so, whom: _____

Who noticed orthodontic problems? ☐ Patient ☐ Dentist ☐ Other: _____

Describe the orthodontic problem in your own words: _____

What concerns you most about the thought of orthodontic treatment?

☐ Appearance in Appliances ☐ Cost ☐ Length of Time ☐ Discomfort ☐ Results ☐ Other: _____

Occupation: _____ No. Years Employed: _____

Employer: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

FAMILY & ACCOUNT INFORMATION

Spouse's Name: _____

Employer: _____ Occupation: _____

Person Responsible for Account: _____

If other than self or spouse:

Name: _____ Occupation: _____

Address: _____ City: _____ Zip: _____

INSURANCE INFORMATION

Name of Insured: (*Employee*) _____ S.S. # _____ Date of Birth: _____

Name of Dental Insurance Company: _____ Insurance Company Ph. # _____

Name of Insured: (*Employee*) _____ S.S. # _____ Date of Birth: _____

Name of Dental Insurance Company: _____ Insurance Company Ph. # _____

I understand that when appropriate, credit bureau records may be obtained.

Signature: (*Parent's signature if minor*) _____

Updates: (*Date & Initial*) _____ _____ _____ _____ _____

EMERGENCY INFORMATION

Name of Nearest Relative Not Living With You: _____

Complete Address: _____

Home Phone: _____ Work Phone: _____

Thank you for supplying the above information . . . David J. Weed, DDS, MSD

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be 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 physician's care? ☐ No ☐ Yes Explain: _____
Is your child currently taking medication? ☐ No ☐ Yes Explain: _____
Is your child allergic to any medications? ☐ No ☐ Yes Explain: _____
Has your child received a blood transfusion? ☐ No ☐ Yes Explain: _____
Have 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

Is there any other condition or problem you think we should know? _____

_____

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? _____
Height: _____ Do you feel growth is completed? ☐ No ☐ Yes
Father's Height: _____ Mother's Height: _____ Adopted? ☐ No ☐ Yes
Names and birthdates of patient's brothers and sisters: _____
Have either siblings or parents had orthodontic treatment? ☐ No ☐ Yes Explain _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____

Frequency of Dental Checkups: ☐ Twice a Year ☐ Once a Year ☐ Only If a Problem Exists ☐ Never Date of Last Visit: _____
Is there unfinished care to be completed with your child's dentist? ☐ No ☐ Yes Explain: _____
Is your child frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Has your child had an unpleasant experience in the dental office? ☐ No ☐ Yes Explain: _____
Has your child had any face or dental injuries? ☐ No ☐ Yes Explain: _____
Is there any history of thumb or finger sucking? ☐ No ☐ Yes Stopped? _____
Does your child play any musical instrument? ☐ No ☐ Yes What Instrument: _____
Has your child consulted an orthodontist previously? ☐ No ☐ Yes With Whom: _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes Explain: _____
Has your child had any previous orthodontic treatment? ☐ No ☐ Yes With Whom: _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____

Please check if there is a history of:

☐ Clenching Teeth
☐ Grinding Teeth
☐ Mouth Breathing: ☐ Awake ☐ Asleep
☐ Speech Problems: If so, what sounds: _____
☐ Muscular Soreness Around Neck & Head
☐ Headaches (More Than Normal)
☐ Jaw Joint Clicking
☐ Jaw Joint Soreness
☐ Jaw Joint Popping
☐ Ringing in the Ears

Is there any other information that may be helpful? _____

Parent's Signature _____ Date: _____ Reviewed by: _____