

Patient Full Name: \_\_\_\_\_

|   |      |   |                       |                           |  |
|---|------|---|-----------------------|---------------------------|--|
| <b>Nickname / Name I Prefer To Be Called:</b> |      | Home Telephone:   |                       |                           |  |
|   |      | Mobile Phone:   |                       |                           |  |
| Patient's Address:                            |      |   |                       | How long at this address: |  |
| Date of Birth:                                | Age: | Sex:  | Employer Telephone:   |                           |  |
| School/Employer:                              |      |   | Length of Employment: | Email Address:            |  |
| Social Security Number:                       |      | For Child Patients, Names and Ages of Brothers & Sisters: |                       |                           |  |

**\*\*\* FOR PATIENTS UNDER 18 YEARS, PLEASE COMPLETE BOTH PARENTS' INFORMATION\*\*\***

|   |  |                        |                     |                           |  |
|---|--|------------------------|---------------------|---------------------------|--|
| <b>Parent Full Name:</b><br>(If you are an adult patient, go to Section Two)<br>€Mother €Father Step-Parent |  | Home Telephone:        |                     |                           |  |
|   |  | Mobile Phone:          |                     |                           |  |
| Address:  |  |                        |                     | How long at this address? |  |
| Employer:   |  |                        | Employer Telephone: |                           |  |
| Length of Employment:   |  | Email Address:         |                     | Marital Status:           |  |
| Social Security Number:   |  | Date of Birth:         |                     |                           |  |
| <b>Other Parent Full Name:</b><br>Mother Father Step-Parent   |  | Home Telephone:        |                     |                           |  |
|   |  | Mobile Phone:          |                     |                           |  |
| Address:  |  |                        |                     | How long at this address? |  |
| Employer:   |  |                        | Employer Telephone: |                           |  |
| Length of Employment:   |  | Occupation / Position: |                     | Marital Status:           |  |
| Social Security Number:   |  | Date of Birth:         |                     |                           |  |

**DENTAL**

**\*\*\*SECTION TWO\*\*\***

**Insurance Information** PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE MAY MAKE A COPY OF IT FOR OUR FILES

|  |                    |  |  |
|--|--------------------|--|--|
| Name of Primary Orthodontic Insurance Co:                    |                    | Insurance Co Telephone #:  |  |
| Name of Policy Holder (Employee):                            |                    | Employee Relationship to Patient:<br>€Mother €Father €Step Parent €Self Spouse €Other (specify): |  |
| Policy Holder Date of Birth:                                 | Policy Holder ID#: | Policy Holder Social Security #:   |  |
| Do you have secondary orthodontic insurance coverage? YES NO |                    |  |  |

**FOR ALL PATIENTS - PLEASE COMPLETE THE FOLLOWING**

|  |  |  |  |
|--|--|--|--|
| How Did You Hear About Us?                 | €Dentist €Patient €Relative €Phone Book €Other |  |  |
| Whom May We Thank For Referring You To Us? | Reason For Today's Visit With Us:              |  |  |
| Present Dentist:                           | Date of Last Dental Cleaning:                  |  |  |

**FOR ALL PATIENTS - PLEASE CHECK ALL THAT APPLY**

|  |                   |   |  |                      |                 |
|--|-------------------|---|--|----------------------|-----------------|
| Aids   | Cancer            | Drug allergies                                    | Heart condition                        | Nervous disorders    | Seizures        |
| Allergies  | Cerebral palsy    | Endocrine problems                                | Hepatitis                              | Painful chewing      | Speech problems |
| Anemia   | Chest pains       | Emotional disorders                               | High blood pressure                    | Periodontal problems | Thumb sucking   |
| Arthritis  | Chronic neck pain | Fainting/dizziness                                | Immune problems                        | Pneumonia            | TMJ problems    |
| Asthma   | Clicking of jaw   | Finger sucking                                    | Kidney problems                        | Pregnant             | Tongue thrust   |
| Autoimmune   | Cold sores/herpes | Glaucoma  | Mouth breathing                        | Prolonged bleeding   | Teeth grinding  |
| Bone disorders   | Diabetes          | Headaches   | Muscular disorders                     | Rheumatic fever      | Tuberculosis    |
| Any disease, problems, or allergies not mentioned above?         |                   |   | Current Medications?                   |                      |                 |
| Females: Have you started Menstruating?                          |                   | (Relevant to status of skeletal growth)           |  | At what age?         |                 |
| Have wisdom teeth been extracted?                                |                   | Are there any missing or extra teeth?             |  |                      |                 |
| Do you normally breathe through the mouth while awake or asleep? |                   | Do you snore?                                     |  |                      |                 |
| Has an orthodontist been consulted previously?                   |                   | Have you had previous orthodontic treatment?      |  |                      |                 |
| Have the tonsils and adenoids been removed?                      |                   | Any other habits? (nail-biting, lip-biting, etc.) |  |                      |                 |
| Any face, mouth or teeth injuries?                               |                   |   | Do gums bleed when brushed or flossed? |                      |                 |

The above information is correct to the best of my knowledge. It is my responsibility to inform you of any changes. I authorize the staff to perform any necessary orthodontic services that I/my child may need during diagnosis and treatment with my informed consent. I understand that I am responsible for payment of services rendered. I understand that you reserve the right to charge for broken appointments or appointments cancelled or changed without 24 hours notice. I understand that credit reports may be obtained at the discretion of this office. I authorize Dr. Dawn S. Wilhite to submit applicable insurance pre-treatment estimates or claims on my behalf.

|  |                          |     |             |                         |       |
|--|--------------------------|-----|-------------|-------------------------|-------|
| I authorize Dawn Wilhite, DMD, PA to release medical and/or financial information. |                          | Yes | To:         | Relationship to patient |       |
|  |                          | No  |             |                         |       |
| Signature:   | Relationship To Patient: |     | Mother      | Father                  | Date: |
|  |                          |     | Step-Parent | Self                    |       |