Patient Full Name: _____

Nickname / Name I Prefer To Be Called:		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*****

Parent Full Name: (If you are an adult patient, go to Section Two) €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:		
Other Parent Full Name: 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: €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 No	To:		Relationship to patient	
Signature:		Relationship To Patient:	Mother Father Step-Parent Self	Date:	