

WELCOME TO OUR OFFICE!

Michael J. Wilson DDS PA

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PATIENT INFORMATION

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____

What name would you like to be called in this office? _____

School _____ Grade _____

Whom may we thank for referring you? _____

Patient: _____ Responsible Party: _____
Email Address Email Address

RESPONSIBLE PARTY INFORMATION

**** (if SELF: please continue to fill out this section)**

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

** How long at this address _____ Home Phone _____ Work Phone _____

** Previous Address (if less than 3 yrs) _____
Street City State Zip

** Social Security # _____ Birth Date _____ Relationship to Patient _____

** Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ ID No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If Yes, please continue: _____

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ ID No. _____

Insurance Co. Address _____

Insured's Employer Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

I understand that where appropriate, credit bureau reports may be obtained.

*****PLEASE CONTINUE TO THE BACK SIDE OF THIS FORM*****

MEDICAL HISTORY

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, LATEX, or Nickel _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have:

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 we have not discussed that you feel we should be aware of? _____

Female Patients: Are you pregnant? Yes No Has menstruation started? Yes No

DENTAL HISTORY

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any permanent teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
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? _____

What is your attitude toward receiving orthodontic treatment? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Do you use tobacco? _____
Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
Yes No Are you aware that some appointments will be during school/work hours? _____

Please list some interests, team sports, or hobbies _____

BENEFITS

Aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Michael J. Wilson to perform a complete orthodontic evaluation.

Patient/Parent Signature: _____ **Date:** _____
Doctor Signature: _____ **Date:** _____