WING ORTHODONTICS

NEW PATIENT FORM

1. PATIENT INFORMATION

Name _____ _____
First MI Last Nickname

Sex _____ Birth Date _____ Age _____ Phone _____

Address _____

City _____ Zip _____

How did you hear about Wing Orthodontics? _____

2. RESPONSIBLE PARTY INFORMATION

FATHER/GUARDIAN or SELF (if Adult Patient) INFO

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Home # _____ Cell _____ Work _____

Email _____ Birth Date _____

Social Security # _____

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State _____ Zip _____

MOTHER/SPOUSE INFORMATION

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Home # _____ Cell _____ Work _____

Email _____ Birth Date _____

Social Security # _____

Are the Patient's Parents Married? Y N

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State _____ Zip _____

ORTHODONTIC INSURANCE INFORMATION

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____ Ext _____

Group # _____

ID or Member # _____

ORTHODONTIC INSURANCE INFORMATION

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____ Ext _____

Group # _____

ID or Member # _____

3. OTHER INFORMATION

Other Children _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

Dentist Name _____

School Name _____ Grade _____

Would you like text message appointment reminders? Y N

Emergency Contact _____
Name Phone #

PATIENT NAME _____

4. MEDICAL INFORMATION

YES	NO		YES	NO		YES	NO	
___	___	Is patient under medical care	___	___	History of fainting or Dizziness	___	___	Latex allergy
___	___	Is patient in good health	___	___	Nervous/emotional problems	___	___	Nickel (metal) allergy
___	___	Heart disease	___	___	Does the patient smoke	___	___	Tuberculosis
___	___	Respiratory disease	___	___	Drug addiction	___	___	Diabetes
___	___	Blood disease	___	___	Is the patient pregnant	___	___	Chemical dependence
___	___	Thyroid disease	___	___	Measles/mumps/chicken pox	___	___	Hemophilia
___	___	Kidney disease	___	___	High/Low blood pressure	___	___	Asthma or hay fever
___	___	HIV/AIDS	___	___	Is height and weight normal	___	___	Rheumatism or arthritis
___	___	Intestinal disease	___	___	Has patient reached puberty	___	___	Tumors or cancer
___	___	Bone disease	___	___	Heart murmur	___	___	Radiation therapy
___	___	Epilepsy	___	___	Heart valve problems			
___	___	Endocrine disease	___	___	Hepatitis			
___	___	Liver disease	___	___	Anemia			
___	___	Prolonged bleeding	___	___	Allergic to anything			

Please list any health problems not mentioned that we should know about

_____

_____

_____

_____

_____

_____

_____

List any medications the patient is taking

_____

_____

_____

5. DENTAL HISTORY

YES	NO		YES	NO	
___	___	Has the patient seen a general dentist in the last year	___	___	Mouth breathing
___	___	Any pain, clicking or discomfort in or near the ears (jaw joints)	___	___	Fingernail biting
___	___	Has the mouth, face or teeth been injured by a fall or accident	___	___	Speech problem or speech therapy
___	___	Have you been informed of missing or extra permanent teeth	___	___	Clenching or grinding teeth
___	___	Are you aware of any "gum" problems	___	___	Tongue thrusting
___	___	Have the patient's tonsils or adenoids been removed	___	___	Have other members of the family had orthodontic treatment
___	___	Thumb or finger sucking (past age 5)			

What would you like to improve about your teeth and smile? _____

Have you ever been evaluated for orthodontic treatment in the past? If so, when? _____

Signature of patient or parent/guardian if patient is a minor _____ Date _____

6. FOR OFFICE USE

_____

_____

_____

_____

FO_____ FC _____ TC _____ Dr. _____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical or dental health or the health of my child.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

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

Signature of person filling out this form _____ Date _____