Patient Information

Welcome to Woodall Orthodontics. Our mission is to provide each patient with the finest care and service in a professional environment that inspires trust and confidence. In order to help us deliver the care you desire, please take a few minutes to fill out this form as thoroughly as possible. Thank you for your attention and we are looking forward to the opportunity to serve you. *If you are utilizing dental insurance, please provide your insurance card so that we can duplicate it and confirm the details of your orthodontic coverage.*

Name: _____ Preferred Name: _____

DOB: _____ SSN: _____ ☐ Male ☐ Female

Home # _____ Cell # _____ Email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Preferred appointment confirmation method: ☐ Text Message ☐ Email

General Dentist: _____ Date of last cleaning & exam: _____

How did you hear about Woodall Orthodontics?_____

What is your primary concern? (Reason for your visit) _____

Complete if patient is a child

School: _____ Hobbies/Sports: _____

Responsible Party: ☐ Mother ☐ Father ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mother: _____ DOB: _____ SSN: _____

Cell # _____ Wk # _____ Email: _____

Employer: _____ Position: _____

Father: _____ DOB: _____ SSN: _____

Cell # _____ Wk # _____ Email: _____

Employer: _____ Position: _____

Insurance Policy Holder? ☐ Mother ☐ Father ☐ None

Complete if you are the patient

Wk # _____ Other # _____ Email: _____

Employer: _____ Position: _____

Spouse: _____ DOB: _____ SSN: _____

Cell # _____ Wk # _____ Email: _____

Employer: _____ Position: _____

Emergency Contact: _____ Cell # _____ Hm # _____

Insurance Policy Holder? ☐ Self ☐ Spouse ☐ None

Please circle **Y** for **yes** or **N** for **no**. If you do not know or are in doubt, leave blank.

MEDICAL HISTORY

Y N Are you in good health at the present time?
Y N Are you presently under the care of a physician for some illness or disease?
Y N Have you been hospitalized or had a serious illness in the last 3 years?
Y N Females Only ~ Are you pregnant or anticipating being pregnant?

Do you have or have you ever had any of the following:

Y N Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, heart defects, endocarditis, etc.)?
Y N High or low blood pressure?
Y N Artificial Valves or Stints?
Y N Abnormal Bleeding?
Y N Kidney / Liver Problems?
Y N Endocrine or thyroid problems?
Y N Asthma?
Y N Cancer?
Y N Convulsions / Epilepsy?
Y N Artificial Bones / Joints?
Y N Handicaps / Disabilities?
Y N Vision, hearing, tasting or speech difficulties?
Y N Diabetes?
Y N Hepatitis?
Y N HIV+ / AIDS?
Y N Rheumatic / Scarlet Fever?
Y N Tuberculosis (TB)?
Y N Mental Health Disturbance or Depression?
Y N Eating Disorder?
Y N Other: _____

Are you allergic or had a reaction to any of the following (circle all that apply):

Y N Local anesthetics (Novocaine, Lidocaine, etc.)?
Y N Aspirin?
Y N Ibuprofen (Motrin, Advil, etc.)?
Y N Penicillin, Sulfa drugs, Other: _____?
Y N Codeine or other narcotics?
Y N Metals (jewelry, clothing snaps) _____?
Y N Latex (gloves, balloons)?
Y N Vinyl?
Y N Acrylic?
Y N Animals?
Y N Foods? (specify)_____
Y N Other substances? (specify)_____

Please list any medications, nutrient supplements, herbal medications or non prescription medicine?

Medication	Taken for?

Y N Have you ever taken any medications for the treatment of bone disorders (Bisphosphonates i.e. Fosamax, Boniva, Actonel, Zometa, etc.)?

Y N Have you smoked/used tobacco products?
How Long? (Yrs) _____ Currently using? Y N

DENTAL HISTORY

Y N Do you drink well water at your house?
Y N Do you brush your teeth at least two times a day?
Y N Do you floss your teeth daily?
Y N Do your gums bleed or ever feel sore?
Y N Have you ever had any dental or periodontal treatment to your gums?
Y N Have you ever had a bad dental experience or are you nervous when visiting the dentist?
Y N Have you ever been evaluated for orthodontic treatment before?
Y N Have you ever had any pain or tenderness in your jaw joints (TMJ)?
Y N Have you ever had any recurring pain or tenderness on or about your face, head or neck?
Y N Have you ever had difficulty in opening or closing your jaw?
Y N Have you ever had any injuries to the face, mouth, teeth or chin?
Y N Do you currently, or did you have a thumb, finger or lip sucking habit after age 4?
Y N Are you self conscious about your teeth or smile?

Please list any other medical or dental problems we should know about.

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature (Responsible Party)_____ **Date:**_____

I understand that the above information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my (my child's) medical status.

Signature (Responsible Party)_____ **Date:**_____