A B C

Patient Information

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birthdate _____ Social Security # _____

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

How did you hear of our office? _____

Responsible Party Information

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 # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

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

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

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

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

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

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

CONFIDENTIAL (for record and pretreatment evaluation)

Wardlaw Orthodontics
Patient Acquaintance Form

Nick Name _____ Sex _____ School _____ Grade _____

Name and ages of other children in family _____

MEDICAL HISTORY

Is patient in good health? _____ Yes _____ No Pregnant? _____ Yes _____ No

Please check box if patient has or has had:

- ____ Heart trouble
- ____ High or low blood pressure
- ____ Heart murmur
- ____ Congenital heart lesion
- ____ Rheumatic fever
- ____ Circulatory problems
- ____ Anemia or hemophilia
- ____ Diabetes
- ____ Tuberculosis
- ____ Frequent headaches
- ____ Faintness / Dizziness
- ____ Malignancies
- ____ Ulcer
- ____ HIV Virus (AIDS)
- ____ Kidney problems
- ____ Epilepsy
- ____ Thyroid problems
- ____ Arthritis or joint swelling
- ____ Prolonged bleeding problems
- ____ Hepatitis or liver problems
- ____ Bone disorders
- ____ Endocrine problems
- ____ Asthma or hay fever *(circle)*
- ____ Emotional problems
- ____ Sinus problems
- ____ Tonsils or adenoid problems
- ____ Tonsils or adenoid removed *(circle)*
- ____ When _____

Name of Physician _____
Is patient under physician's care presently? _____ Yes _____ No Reason _____
List any other serious illnesses or major operations: _____
List any allergies or medications now being taken and reasons _____
Does Patient need premedication prior to dental work? _____ Yes _____ No
Explain _____
Does patient have tendency to colds? _____ Sore throats? _____ Ear infections? _____
Has patient reached puberty? _____ Males - voice changed? _____ Yes _____ No
Females - started menstruation? _____ Yes _____ No
Describe patient's temperament _____
Patient will probably be _____ eager to cooperate _____ cooperative _____ unwilling
but will go along _____ uncooperative

DENTAL HISTORY

Please check if answer is YES:

- ____ Any injuries to face, mouth, teeth? *(circle)*
- ____ Parts of mouth sensitive to temperature, pressure, food or drink?
- ____ Frequent canker (cold) sores?
- ____ Any extra or missing permanent teeth? *(circle)*
- ____ Any teeth removed by extractions?
- ____ Bleeding or swollen gums?
- ____ Growths, swellings or sores in mouth?
- ____ Any speech, or hearing problems? *(circle)*
- ____ Mouth breathing when asleep, awake? *(circle)*
- ____ Thumb, finger, lip sucking? *(circle)*
- ____ Any pain or clicking on opening mouth? *(circle)*
- ____ Difficulty in opening mouth widely?
- ____ Jaw ever locked?
- ____ Grinding or clenching of teeth?
- ____ Musical instruments played?
- ____ Headaches frequently?

I authorize the following individuals to act as appointed healthcare representatives with whom my child's health information may be discussed:

_____

_____

I have received and/or reviewed a copy of Wardlaw Orthodontics, P.A.'s Notice of Privacy Practices. *(You may refuse to sign this acknowledgment.)*

Guarantor Signature: _____

Date: _____

For Office Use Only: We could not obtain written acknowledgment of receipt of our Notice of Privacy Practices because:

Staff Signature: _____

Date: _____

Name of Dentist _____
Does patient visit dentist regularly? _____ Date of last dental visit _____
Has an orthodontist been consulted previously or has patient had previous orthodontic treatment? _____
Reason _____
Name of orthodontist _____
What is the patient's (or parents') primary concern *(why are you here)*? _____

_____

Whom may we thank for referring you _____

SIGNATURE *(Parent's signature if minor)* _____
Date _____

WARDLAW ORTHODONTICS RESERVES THE RIGHT TO REFUSE TREATMENT TO ANYONE.