



# Carl Walker ORTHODONTICS

Patient's Full Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Main Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

City/State \_\_\_\_\_ Zipcode \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Male/Female School Name \_\_\_\_\_ Grade \_\_\_\_\_

Sports or Hobbies \_\_\_\_\_ # of Siblings & Ages \_\_\_\_\_

Dentist Name \_\_\_\_\_ Dentist Phone \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_ If online, what search engine/site? \_\_\_\_\_

If referred by a friend, please give friend's name \_\_\_\_\_

## Self or Responsible Party

## Spouse or Other Parent/Guardian

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Main Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Main Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

DL # \_\_\_\_\_ SS# \_\_\_\_\_

DL # \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Years Employed \_\_\_\_\_

Work Phone \_\_\_\_\_ Years Employed \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

## Insurance Information

*For most orthodontics, you **MUST** have an orthodontic rider on your dental insurance.  
We are happy to file your primary insurance as a courtesy; however, payments will be paid directly to you.  
Payment for services rendered is due in full at time of service.*

Insurance Company \_\_\_\_\_ Contract/Policy ID# \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Group # \_\_\_\_\_ Lifetime Maximum Amount \_\_\_\_\_

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

Patient /Parent Signature \_\_\_\_\_

# Medical History

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Frequent/ Severe headaches | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Chicken Pox                   |
| <input type="checkbox"/> Heart disease              | <input type="checkbox"/> Polio                          | <input type="checkbox"/> Measles/Mumps                 |
| <input type="checkbox"/> Sinus/Respiratory          | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Pregnant                      |
| <input type="checkbox"/> Blood disease              | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Fainting/Dizziness            |
| <input type="checkbox"/> Liver disease              | <input type="checkbox"/> Mononucleosis                  | <input type="checkbox"/> Joint Problems                |
| <input type="checkbox"/> Thyroid disease            | <input type="checkbox"/> Hemophilia                     | <input type="checkbox"/> Drug Addiction                |
| <input type="checkbox"/> Kidney disease             | <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Radiation Therapy             |
| <input type="checkbox"/> HIV positive               | <input type="checkbox"/> Heart Murmur                   | <input type="checkbox"/> Chemical Therapy              |
| <input type="checkbox"/> Venereal disease           | <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Blood Transfusions            |
| <input type="checkbox"/> Intestinal disease         | <input type="checkbox"/> Rheumatic/Yellow/Scarlet Fever | <input type="checkbox"/> Smoke                         |
| <input type="checkbox"/> Bone disease               | <input type="checkbox"/> HIV positive                   | <input type="checkbox"/> Menstruation (Females)        |
| <input type="checkbox"/> Nervous/emotional          | <input type="checkbox"/> AIDS                           | <input type="checkbox"/> Shaving (Males)               |
| <input type="checkbox"/> High/Low Blood Pressure    | <input type="checkbox"/> Rheumatism or Arthritis        | <input type="checkbox"/> Physical within the last year |
| <input type="checkbox"/> Endocrine Problems         | <input type="checkbox"/> Asthma or Hay fever            | <input type="checkbox"/> Latex Allergy                 |
| <input type="checkbox"/> Problems w/wounds healing  | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Nickel Allergy                |
| <input type="checkbox"/> Tumors or Cancer           | <input type="checkbox"/> Broken Bones                   | <input type="checkbox"/> Other Allergy (non- medicine) |
| <input type="checkbox"/> Frequent sore throats      | <input type="checkbox"/> Prolonged Bleeding             | <input type="checkbox"/> Autism (detail below)         |
|   | <input type="checkbox"/> Fever blisters                 |  |
|   | <input type="checkbox"/> Yellow jaundice                |  |

If yes to any of the above, please explain \_\_\_\_\_

Allergic to any medicines? \_\_\_\_\_ If yes, what? \_\_\_\_\_

List medications taken regularly: \_\_\_\_\_

# Dental History

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dental checkup in last year      | <input type="checkbox"/> Cheek/tongue/ lip chewing | <input type="checkbox"/> Clenching teeth                 |
| <input type="checkbox"/> Clicking/discomfort in/near ears | <input type="checkbox"/> Thumb sucking             | <input type="checkbox"/> Tongue thrusting                |
| <input type="checkbox"/> Injury to face/mouth/teeth       | <input type="checkbox"/> Mouth breathing           | <input type="checkbox"/> Grinding teeth                  |
| <input type="checkbox"/> Missing or extra permanent teeth | <input type="checkbox"/> Nail biting               | <input type="checkbox"/> Speech problems                 |
|   | <input type="checkbox"/> Tongue thrusting          | <input type="checkbox"/> Gum problems                    |
|   | <input type="checkbox"/> Speech problems           | <input type="checkbox"/> Previous orthodontic evaluation |

Have any other members of family had orthodontic treatment? \_\_\_\_\_ If so, when? \_\_\_\_\_

Were you happy with the results? \_\_\_\_\_ If not, why not? \_\_\_\_\_

Is patient happy with his/her smile? \_\_\_\_\_

Describe your orthodontic problem \_\_\_\_\_

What would you like your orthodontic treatment to accomplish? \_\_\_\_\_