Carl Walker ORTHODONTICS

Patient's Full Name _____Nickname _____Date _____

Address _____ Main Phone _____Alt Phone_____

City/State _____ Zipcode _____Email_____

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

Name_____

Address _____

City/State/Zip _____

Main Phone _____Alt Phone_____

Birthdate _____ Age _____Marital Status _____

DL #_____SS#_____

Employer _____

Employer Address_____

City/State/Zip_____

Work Phone _____Years Employed _____

Occupation _____

## Spouse or Other Parent/Guardian

Name_____

Address _____

City/State/Zip _____

Main Phone _____Alt Phone_____

Birthdate _____ Age _____Marital Status _____

DL #_____SS#_____

Employer _____

Employer Address_____

City/State/Zip_____

Work Phone _____Years Employed _____

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

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

If yes to any of the above, please explain _____

_____

Allergic to any medicines? _____ If yes, what? _____

List medications taken Regularly:_____

# Dental History

- ☐ Dental checkup in last year
- ☐ Clicking/discomfort in/near ears
- ☐ Injury to face/mouth/teeth
- ☐ Missing or extra permanent teeth
- ☐ Cheek/tongue/ lip chewing
- ☐ Thumb sucking
- ☐ Mouth breathing
- ☐ Nail biting
- ☐ Tongue thrusting
- ☐ Speech problems
- ☐ Clenching teeth
- ☐ Tongue thrusting
- ☐ Grinding teeth
- ☐ Speech problems
- ☐ Gum problems
- ☐ 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? _____