Drs. Weidman and Hazey III, D.D.S., M.S. *Specialists in Orthodontics*

1. Patient Information

Todays's date_____ M_____ F____
Name:_____
last *first* *m*
Nickname_____ SS# _____
Birth Date:_____Age: _____
School _____ Grade:____
Home Phone#: (___) _____
Home Address_____
_____
city *state* *zip*
Height_____Weight_____
Referred by:_____
General Dentist_____
Last visit date:_____
Parent marital status: Single Married
Separated Widowed Divorced

2.) Father Information

Name:_____
Address:_____
Home Phone # (___) _____
Work Phone # (___) _____
Employer:_____
Occupation:_____
SS#_____

3). Mother Information

Name:_____
Address:_____
Home Phone # (___) _____
Work Phone # (___) _____
Employer:_____
Occupation:_____
SS#_____

4). Responsible Party Information

Name:_____
Relation:_____
BillingAddress:_____
E-MailAddress:_____
Home Phone # (___) _____
Work Phone # (___) _____
Employer:_____
Occupation:_____
SS#_____

5).Primary Orthodontic Insurance

Orthodontic Coverage? Yes_____ No_____
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #: (___) _____
Group# (Plan, Local, or Policy #):_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's Birth Date:_____
SS#_____
Policy Owner's Employer:_____
_____

6. MEDICAL HISTORY

Y	N	Abnormal bleeding
Y	N	Allergies to any Drugs
Y	N	Allergic to Latex or Metals
Y	N	Allergic to Plastics
Y	N	Anemia
Y	N	Asthma
Y	N	Bone Disorders
Y	N	Cancer
Y	N	Colds/Sore Throats
Y	N	Congenital Heart Defects
Y	N	Convulsions/Epilepsy
Y	N	Diabetes
Y	N	Endocrine Problems
Y	N	Fainting or Dizziness
Y	N	Handicaps/Disabilities
Y	N	Hearing Impairment
Y	N	Heart Trouble/Murmur
Y	N	Hemophilia
Y	N	Hepatitis
Y	N	HIV+/AIDS
Y	N	Kidney/Liver Problems
Y	N	Liver Involvement
Y	N	Major Illness
Y	N	Menstruation
Y	N	Nervous Disorders
Y	N	Pneumonia
Y	N	Puberty
Y	N	Rheumatic/Scarlet Fever
Y	N	Seasonal Allergies
Y	N	Tonsils/Adenoids Removed/Age?__
Y	N	Tuberculosis

Drugs that patient is allergic to: _____
Drugs now being taken /reason:_____
_____
_____

Dental History

Family Dentist_____ Date of last dental visit_____

No. of checkups per year ( ) Once ( ) Twice ( ) Only if urgent ( ) Never
Has the patient had a previous orthodontic consultation or treatment? ( ) No ( ) Yes
Date: _____

History of:			If yes, mark those that apply:	Please explain
Tooth injury	( )No	( )Yes	( )Chipped ( )Broken ( )Lost	_____
Oral Disease	( )No	( )Yes	( )Decay ( ) Ulcers ( )Sores	_____
Jaw Joint Noises	( )No	( )Yes	( )Right ( )Left ( )Both	_____
Grinding your teeth	( )No	( )Yes	( )During day ( )When sleeping	_____
Clenching your teeth	( )No	( )Yes	( )During day ( )When sleeping	_____
Bleeding gums	( )No	( )Yes	( )Usually ( )Sometimes ( )When brushing ( )Flossing	
Oral habits	( )No	( )Yes	( )Thumb/finger sucking ( )Tongue thrusting ( )Other	
Airway Problems	( )No	( )Yes	( )Mouth breathing ( )Other	
Speech therapy	( )No	( )Yes	If yes, advised by:_____	

Why did the patient/parent seek this consultation?

( ) To correct overbite	( )Crowding	( )Jaw dysfunction
( ) Eliminate facial pain	( )Close spaces	( )Improve facial proportions
( ) Improve general appearances	( )Improve facial proportions	( )Other:_____

Orthodontic consultation prompted by:
( )Patient ( )Dentist ( )Mother ( )Father ( )Sibling ( )Friend

Names of siblings & birthdates:_____

Tell us about you !!!!!!!!!!!!

How do you feel about braces? _____
Any specific hobbies? _____
Any pets? _____
Do you have a nickname? _____
Do you play a musical instrument? _____
Do you play any sports? _____

I certify that I have reviewed the above medical/dental history and it is accurate to my knowledge at this time. If there are any future changes in this information I will inform Drs. Weidman and Hazey.

_____

Signature Date