



# WESTLAKE FAMILY ORTHODONTICS

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## NEW PATIENT FORM

Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_

Please provide your General Dentist name and Number: \_\_\_\_\_

Do you Dental Insurance we can verify for you? Yes No Have we already been given this information? Yes No

Responsible Party Name: \_\_\_\_\_ Number: \_\_\_\_\_

Relationship to Patient: Circle: Mother Father Grandmother Aunt/Uncle Legal Guardian

### INSURANCE INFORMATION:

Policy holder name: \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy Holder contact number: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ ID /SSN \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer's name: \_\_\_\_\_

Relationship to Patient: Circle one: Partner Spouse Dependent Self

Main Concerns for your visit today: \_\_\_\_\_

Who may we thank for your referral: \_\_\_\_\_ Number: \_\_\_\_\_

When was your last dental check-up? \_\_\_\_\_

Do you have any dental fillings to be completed? \_\_\_\_\_

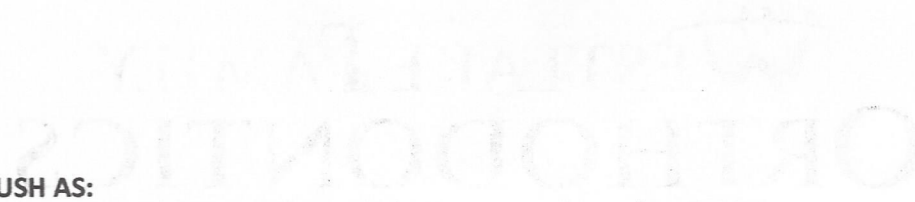
Do you have any immediate family with our office: Circle (Sister) (Brother) (Father) (Mother) YES NO

Their name's: \_\_\_\_\_

Do you know anyone in braces or Invisalign? Circle YES NO

What are your favorite foods? \_\_\_\_\_

What is your interest to straighten your teeth? Invisalign Clear Braces Metal Braces



**ANY HEALTH PROBLEMS SUSH AS:**

\_\_\_ Blood disorders Yes No If yes please explain

\_\_\_\_\_

\_\_\_ Heart Murmurs Yes No If Yes, are antibiotics required before invasive dental procedures? Yes No

Please provide Treating Cardiologist name and number: \_\_\_\_\_

\_\_\_ HIV or AIDS

\_\_\_ Hepatitis

\_\_\_ Diabetes Circle Type A Type B (juvenile)

Do you Smoking? Yes No

Do you drink tea or coffee? Yes or No

Handicaps: Yes No Yes, if yes please explain

\_\_\_\_\_

Any Mental Health Concerns to be aware of

\_\_\_\_\_

Are you taking any medication Yes or No If yes, please list the name and dosages

\_\_\_\_\_

Are you activity in sport requiring a mouth piece? \_\_\_ Yes \_\_\_ No

Any other health concerns we should be aware of before we start orthodontic treatment?

\_\_\_\_\_

\_\_\_\_\_

You, Patient or Responsible Party, are encouraged to review the information contained in this Health History disclosure form and ask any questions you may have if you are unsure of your oral and physical health problems. Should any changes occur to this information; updated information will be provided to WFO within a reasonable time frame. I acknowledge my responsibility to adhere to the oral and health information provide.

I hereby acknowledge the receipt of my disclosures made above and is true and accurate to the best of my knowledge.

\_\_\_\_\_

Patient/Responsible Party Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Treatment Coordinator/Orthodontist Signature