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