WESTLAKE FAMILY ORTHODONTICS

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Patient Name: ______________________________ Nickname: __________________ DOB: ______________

Address: ____ City/ State/ Zip: __________________________

Email: ____ Cell Phone: _____________________________

Whom may we thank for referring you: ____

Dental Insurance Information: (This may differ from your medical insurance.)

Name of Insurance Company: _________________________________ Phone: __________________________

Policy Holder Name: _________________________________ Policy Holder's DOB: _____________________

Relationship to Patient: (Circle One) Parent/Guardian Self Partner/Spouse

Member ID/SSN: ___________________________________ Group/Policy Number: _____________________

Name of Employer: _________________________________

Dental History:

Main concern(s) for today's visit: ____

Dentist Name: ______________________________________ Date of last check-up: ______________________

Do you have any dental treatment to be completed? ____

Have you ever had or been evaluated for orthodontic treatment? _______________________________________

What options are you interested in to straighten your teeth? (Circle all that apply)

Metal Braces Clear Braces Invisalign Replace Retainers only

Have you ever had an unfavorable experience associated with dental work? ______________________________

Have you ever had an injury to your mouth, teeth, or chin? ____

Are you aware of any missing or extra permanent teeth? ____

(continued on back) →

Medical History:

Are you taking any prescription / over-the-counter drugs? ______________________________

If so, please list each: ____

Have you ever had any of the following medical concerns? (Please check all that apply)

○ Bleeding disorder	○ Asthma or Emphysema	○ Mental health disorder
○ Anemia	○ Epilepsy / seizures	○ Migraines / severe headaches
○ Artificial bones, joints, valves	○ Fever blisters / Herpes	○ Shingles
○ Blood transfusion	○ Glaucoma	○ Sickle Cell disease
○ Cancer/ chemotherapy	○ Heart murmur / Pacemaker	○ Tuberculosis
○ Congenital heart defects	○ High / Low blood pressure	○ Ulcers / Colitis
○ Diabetes	○ HIV /AIDS	○ Other (please explain):
○ Drug Abuse	○ Kidney problems	

Are there any other medical concerns that you would like us to be aware of? ____________________

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Are you allergic to any of the following? (Please check all that apply)

○ Aspirin	○ Latex
○ Metals or Plastics	○ Penicillin
○ Codeine	○ Tetracycline
○ Dental Anesthetics	○ Other (please indicate):
○ Erythromycin	

Emergency Contact:

In the event of an emergency, is there someone who lives near you that we should contact?

Name: ______________________________ Relationship: ____________________

Cell Phone: ____________________________ Other Phone: ____________________

Thank you for filling out this form completely.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

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Signature Date