WESTLAKE FAMILY ORTHODONTICS

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Patient Name: ______________________________ Nickname: __________________ DOB: ______________

Parent/Guardian Name(s): ____

Patient Address: _____________________________________ City/ State/ Zip: ___________________________

Contact 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: ______________________

Is there any dental treatment to be completed? ____

Has your child ever had or been evaluated for orthodontic treatment? ___________________________________

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

Metal Braces   Clear Braces   Invisalign

Has your child ever had an unfavorable experience associated with dental work? ________________________

Has your child ever had an injury to their mouth, teeth, or chin? ______________________________________

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

(continued on back) →

Medical History:

Please list any prescription / over-the-counter medications your child is currently taking?

____

Has your child 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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Is your child 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 | Relation to Patient | Date