WHITE ORTHODONTICS
beyond straight teeth

We would like to welcome you to our office. In an effort to provide the best service possible and conduct a thorough examination, please fill out this form completely. Thank you for your cooperation.

Patient Information

Name: _____ Sex: ☐ Male ☐ Female
(Last / First / Middle)

Preferred Name: _____ Marital Status: _____

Address: _____
(Street / City / State / Zip)

Birth Date: _____ E-Mail: _____ Social Security #: _____
(MM-DD-YYYY) (999-99-9999)

Home Phone: _____ Cell Phone: _____ Work Phone: _____ ext: _____
((999) 999-9999) ((999) 999-9999) ((999) 999-9999)

Employer: _____ Occupation: _____ # Years Employed: _____

General Dentist: _____ Last Visit: _____

Whom may we thank for referring you to our office? _____

Spouse / Additional Responsible Party

Name: _____ Sex: ☐ Male ☐ Female
(Last / First / Middle)

Preferred Name: _____ Marital Status: _____

Address: _____
(Street / City / State / Zip)

Birth Date: _____ E-Mail: _____ Social Security #: _____
(MM-DD-YYYY) (999-99-9999)

Home Phone: _____ Cell Phone: _____ Work Phone: _____ ext: _____
((999) 999-9999) ((999) 999-9999) ((999) 999-9999)

Employer: _____ Occupation: _____ # Years Employed: _____

Relationship to Patient: _____

Insurance Information

Policy Owner's Name: _____ Policy Owners Social Security # : _____
(999-99-9999)

Policy Owner's Birthdate: _____ Relationship to Patient: _____
(MM-DD-YYYY)

Policy Owner's Employer: _____ Employer's Address: _____

Insurance Company: _____ Group No. (plan,local,or policy): _____

Insurance Co. Address: _____ Insurance Phone No. _____

Medical History

Has the patient had or does the patient have any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	High Blood Pressure
☐	☐	Allergies	☐	☐	Clicking of the Jaws	☐	☐	Gout	☐	☐	Immune Problems
☐	☐	Arthritis	☐	☐	Contact Lenses	☐	☐	Headaches	☐	☐	Kidney Problems
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Heart Condition	☐	☐	Low Blood Pressure
☐	☐	Bone Disorders	☐	☐	Drug Allergies	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse
☐	☐	Bulimia	☐	☐	Emotional Disorders	☐	☐	Hepatitis	☐	☐	Metal Allergies
☐	☐	Blood Disorders	☐	☐	Epilepsy	☐	☐	Herpes	☐	☐	Rheumatic Fever

Please explain answers to questions above to which you answered yes:_____

Primary Care Physician: _____ Physician's Phone #: _____

Are you currently under the care of a physician: ☐ Yes ☐ No If yes, please explain: _____

Any diseases, problems, or allergies not mentioned above? _____

Are you taking Bisphosphonates (Fosamax, Zometa, Boniva, Actonel)? ☐ Yes ☐ No If yes, dosage: _____

Please list any other current medications and dosages: _____

Have your tonsils or adenoids been removed? ☐ Yes ☐ No

Do you smoke or use tabacco in any form? ☐ Yes ☐ No

Dental History

Y	N		Y	N	
☐	☐	Bleeding Gums	☐	☐	Mouth Breathing
☐	☐	Headaches	☐	☐	Speech Problems
☐	☐	Jaw Joint Noises	☐	☐	Swallowing difficulties
☐	☐	Jaw Locking	☐	☐	Tongue Thrusting
☐	☐	Lip Sucking / Biting	☐	☐	Tooth Grinding / Clenching

For Women Only

Are you taking birth control pills?	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Do you have any metal or jewelry allergies?	☐ Yes ☐ No

Previous Periodontal Evaluation/Treatment? ☐ Yes ☐ No Periodontist: _____ Date: _____

Are there any missing permanent teeth? ☐ Yes ☐ No

Are there any extra permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to: ☐ Teeth ☐ Mouth ☐ Chin

Reason for orthodontic consultation? _____

Previous Orthodontic Exam? ☐ Yes ☐ No Orthodontist: _____ Date: _____

Previous Orthodontic Treatment (Patient)? ☐ Yes ☐ No Orthodontist: _____ Satisfied w/results? ☐ Yes ☐ No

Previous Orthodontic Treatment (Family)? ☐ Yes ☐ No Orthodontist: _____ Satisfied w/results? ☐ Yes ☐ No

Authorization

I hereby authorize the release of medical and dental information to insurance carriers and to other health care providers involved in my treatment and the use of records by Dr. White for teaching purposes, scientific publications, office marketing, office displays and website display. The information provided above is complete and correct to the best of my knowledge. I agree to inform this office of any changes in my medical or dental status as they occur. I understand that where appropriate, credit reports may be obtained.

Signature: _____ Date: _____