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: _____ (Last) _____ (First) _____ (Middle)

Preferred Name: _____ Sex: ☐ Male ☐ Female

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

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

Home Phone: _____ ((999) 999-9999) General Dentist: _____ Last Visit: _____

School: _____ Grade: _____ Hobbies: _____

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

Father / Responsible Party

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

Preferred Name: _____ Marital Status: _____

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

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

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

Employer: _____ Occupation: _____ # Years Employed: _____

Relationship to Patient: _____

Mother / Responsible Party

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

Preferred Name: _____ Marital Status: _____

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

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

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

Employer: _____ Occupation: _____ # Years Employed: _____

Relationship to Patient: _____

Insurance Information

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

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

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 the patient's tonsils been removed? ☐ Yes ☐ No

Have the patient's adenoids been removed? ☐ Yes ☐ No

Dental History

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

Growth & Development

Current Height: _____ Expected Height: _____

Father's Height: _____ Mother's Height: _____

Has patient reached adolescent growth spurt? ☐ Yes ☐ No

Has patient begun puberty? ☐ Yes ☐ No

Boys: Has voice changed? ☐ Yes ☐ No Pubic Hair? ☐ Yes ☐ No ☐ N/A

Girls: Has menstration (period) begun? ☐ Yes ☐ No ☐ N/A

Thunb/Finger Sucking? _____ Previously _____ Presently

Are there any missing permanent teeth? ☐ Yes ☐ No

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

Are there any extra permanent teeth? ☐ Yes ☐ No

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

Name and ages of siblings? _____

Authorization

I hereby authorize the release of medical and dental information to insurance carriers and to other health care providers involved in the treatment of this patient and the use of records by Dr. White for teaching purposes, scientific publications, office marketing, office display 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 child's medical or dental status as they occur. I understand that where appropriate, credit reports may be obtained.

Signature: _____ Date: _____