Wentz Orthodontics

FAIRBANKS, ALASKA • (907) 452-7223 • WWW.WENTZORTHO.COM

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

1 ABOUT YOU

Today's Date: ____________

E-mail Address: ____________

Name: ____________
LAST FIRST MI MR MRS MS DR

I prefer to be called: ____________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ______ SS #: ____________

Physical Address: ____________ APT/CONDO #

____
CITY STATE ZIP

Mailing Address: ____________ APT/CONDO #

____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

Hm #: (____) ____________ Cell #: (____) ____________

Wk #: (____) ____________ Ext: ______ DL #: ____________

Employer: ____________

Employer's Address: ____________
CITY STATE ZIP

How long there? ________ Occupation: ____________

Where & when are the best times to reach you? ____________

Whom may we Thank for referring you? ____________

Other family members seen by us: ____________

Dentist: ____________ ☐ Previous ☐ Present

Last Visit Date: ____________

2 SPOUSE INFORMATION

His/Her Name: ____________ Birthdate: ___/___/___

Employer: ____________

Wk #: (____) ____________ Ext: ______ SS #: ____________

Hm #: (____) ____________ Cell #: (____) ____________

Person Responsible for Account: ____________

Wk #: (____) ____________ Ext: ______ Hm #: (____) ____________

Billing Address: ____________

Relation: ____________ SS #: ____________

Employer: ____________ DL #: ____________

3 ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

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

His/Her Name: ____________ Relation: ____________

Wk #: (____) ____________ Hm #: (____) ____________

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________

Phone #: (____) ____________ Date of last visit: ____________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

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

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one:______________________________

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Week #:_______

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for any reason
Y	N	Artificial Bones /Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer/ Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treatment
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic /Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease
Y	N	Hepatitis			

Please list any other medical condition(s) that you have ever had:

____

____

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metals/Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to:

____

____

5 DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

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

Do you have any speech problems? ☐ Yes ☐ No
If yes, please tell us:______________________________

Do you generally breathe through your mouth? ☐ Yes ☐ No
If yes, please check: ☐ While awake? ☐ While asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

How many times a week do you floss?______________________________

How many times a day do you brush?______________________________

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 dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature Date

THANK YOU

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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