



DR. WAYNE J. CHRISTIAN
FAMILY ORTHODONTICS
"Building Generations of Smiles"

Patient Information:

Date _____
Name: Last _____ **First** _____ **Middle** _____
Birthdate _____ **Age** _____ **M / F** **Nickname** _____
Street Address _____ **City** _____ **St** _____ **Zip** _____
Mailing Address _____ **City** _____ **St** _____ **Zip** _____
Home Phone _____ **Cell Phone** _____ **School** _____ **Grade** _____
Siblings (Names & Ages) _____

Whom may we thank for referring you to our office?

Father's Name _____ **Hm Ph** _____ **Cell** _____ **Wk** _____
Mother's Name _____ **Hm Ph** _____ **Cell** _____ **Wk** _____

Primary Responsible Party Information:

Last Name _____ First _____ MI _____ Marital status _____
Street Address _____ City _____ St _____ Zip _____
Mailing Address _____ City _____ St _____ Zip _____
How long at this address _____ Own / Rent Hm Phone _____ Wk/Cell Ph _____
Soc. Sec. # _____ **Birthdate** _____ **Relationship to Patient** _____
Employer _____ Occupation _____ No. Yrs. employed _____
Previous employer(if less than 3 yrs.) _____ No. Yrs. employed _____
Best time to contact you: Morning / Afternoon / Evening. Can you be reached at work? Yes / No

Secondary Responsible Party Information:

Last Name _____ First _____ MI _____ Birthdate _____
Mailing Address _____ City _____ St _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Soc. Sec. # _____ Relationship to patient _____
Employer _____ Occupation _____ No. Yrs. Employed _____
Best time to contact you: Morning / Afternoon / Evening. Can you be reached at work? Yes / No

Insurance Information:

Insurance Co. _____ Employer _____
Insurance Co. Address _____ Phone _____
Insured's Name _____ Soc. Sec. # _____ Birthdate _____
DO YOU HAVE A SECONDARY INSURANCE? Yes / No B If yes:
Insurance Co. _____ Employer _____
Insurance Co. Address _____ Phone _____
2nd Insured's Name _____ Soc. Sec. # _____ Birthdate _____

Emergency Information:

Name of nearest relative/friend not living with you _____ Relationship _____
Complete Address _____ Phone _____

PLEASE FILL OUT BOTH SIDES OF THIS FORM COMPLETELY AND BRING IT WITH YOU TO YOUR APPOINTMENT. PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST TO COPY. WE LOOK FORWARD TO SERVING YOU.

Medical History:

Name of Medical Physician _____ Phone _____ Last visit _____

Is the Patient currently under the care of a Physician? Yes / No

If yes, please explain _____

Has the patient ever had any of the following diseases or medical problems?

Abnormal Bleeding	Yes / No	Allergic to Latex/Metals	Yes / No
Allergic to Plastic	Yes / No	Asthma	Yes / No
Cancer	Yes / No	Congenital Heart Defect	Yes / No
Convulsions/Epilepsy/Seizures	Yes / No	Diabetes	Yes / No
Handicaps / Disabilities	Yes / No	Hearing Impairment	Yes / No
Heart Murmur	Yes / No	Hemophilia	Yes / No
Hepatitis	Yes / No	HIV/Aids	Yes / No
Kidney/Liver problems	Yes / No	Rheumatic/Scarlet Fever	Yes / No
Tuberculosis	Yes / No	Difficulty Breathing	Yes / No
Psychiatric Problems	Yes / No	Fever Blisters/Herpes	Yes / No

Patient's current medical health is: Good / Fair / Poor

Is the patient taking any prescription / over the counter drugs? (Aspirin, Tylenol, ect.)? Yes / No

If yes, please list: _____

Please list any allergies (including drug allergies): _____

Please list any other medical problems past and present: _____

Any Hospital stays / operations? Yes / No if yes, for what and how long ago? _____

Dental History:

Name of Dentist _____ Phone _____ Last visit _____

Is all dental work completed? Yes / No If no, please explain _____

What results would you like to achieve with Orthodontics? _____

What bothers you the most about your teeth / bite at present? _____

Current dental health is: Good / Fair / Poor

Previous orthodontic treatment?	Yes / No	Any problems with bleeding gums?	Yes / No
Any speech problems?	Yes / No	Any missing/extra <i>permanent</i> teeth?	Yes / No
Any mouth breathing while awake?	Yes / No	Any mouth breathing while sleeping?	Yes / No
Have adenoids/tonsils been removed?	Yes / No	Any jaw joint noises or tenderness?	Yes / No

Any injuries to the: Mouth / Teeth / Chin / Head - If so, please explain _____

List any musical instrument played: _____

Habits:

Clenching	Yes / No	Grinding	Yes / No	Nail biting	Yes / No
Lip Sucking/Biting	Yes / No	Tongue Thrust	Yes / No	Thumb/Finger sucking	Yes / No

We want to get better acquainted. Please take a minute to tell us about the patient.

(hobbies, achievements, favorites, likes and dislikes.) Anything to help us get to know

YOU! _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

I understand the information given is correct to the best of my knowledge. I also understand that information given will be held in strict confidence and that it is my responsibility to inform this office of any changes in the patient's medical/dental status. I understand that where appropriate, credit bureau reports may be obtained. I authorize Dr. Christian and staff to perform any necessary dental services that may be needed during diagnosis and treatment.

Parent /Patient signature

Date