West orthodontics

***Please Completely Fill in All Information***

Patients Preferred Name: _____ Email Address: _____

Patients Address: _____ Telephone: _____ Cell Phone: _____

Birth date: _____ Age: _____ Male: _____ Female: _____

School/Employer: _____ Grade/Position: _____

Interest/Sports _____

## ***Self*** *or Primary Responsible Party*

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Name: _____ Telephone: _____ Cell Phone: _____

Address: _____ **Years At This Address?** _____ **Own** ☐ **Rent** ☐

Employer: _____ Occupation: _____ Years Employed? _____

Social Security Number: _____ Date of Birth: _____

**Marital Status:** **Married** ☐ **Single** ☐ **Divorced** ☐

## ***Spouse*** *or Secondary Responsible Party*

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Name: _____ Telephone: _____ Cell Phone: _____

Address: _____ **Years At This Address?** _____ **Own** ☐ **Rent** ☐

Employer: _____ Occupation: _____ Years Employed? _____

Social Security Number: _____ Date of Birth: _____

**Marital Status:** **Married** ☐ **Single** ☐ **Divorced** ☐

## ***In case of an emergency, whom shall we contact?***
## ***(Please list someone other than above)***

Name: _____ Relationship: _____ Address: _____

Primary Phone: _____ Secondary Phone: _____

How Did You Hear About Us? ☐ My Dentist ☐ Patient Of Dr. West ☐ Relative ☐ Acquaintance ☐ Other _____

Please List Name(s) Of Referral Source(s) so we may thank them: _____

Please List relatives or close friends seen in our office: _____

Present Dentist: _____ Last Visit : _____ Reason For Visit? _____

Reason For Considering Orthodontics: _____

Has An Orthodontist Been Consulted Previously? _____ If Yes Please List Name Of Orthodontist: _____

Have you had previous orthodontic treatment? _____ If Yes Please List Name Of Orthodontist: _____

What is the patient's attitude toward wearing braces if necessary? Eager ☐ Willing ☐ Will, if they have to ☐ Against ☐

Does the Patient prefer braces or Invisalign? _____

## *Insurance Information* *(Please fill out completely so we may properly file your insurance)*

Name of Primary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Policy Holders Date Of Birth: _____ Social Security Number: _____

Insurance ID Number: _____ Group Number: _____

Name of Secondary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Policy Holders Date Of Birth: _____ Social Security Number: _____

Insurance ID Number: _____ Group Number: _____

**Please provide your insurance card(s) to be copied at the front desk.**

***Remember insurance is not a substitute for payment. We request that charges for office visits be paid at the conclusion of each visit.***

***I herby authorize payment directly to Lance E. West DMD MS PC. I also authorize "signature on file" to be used on insurance forms.***

Signature of Responsible Party: _____ Relationship To Patient: _____ Date: _____

## *Health History* *Check box for which the patient has a history:*

| | | | | | |
|---|---|---|---|---|---|
| ☐ AIDS | ☐ Chemotherapy | ☐ Emotional disorders | ☐ Hay Fever | ☐ Hypoglycemia | ☐ Sinus Trouble |
| ☐ Alcohol Dependency | ☐ Cancer | ☐ Endocrine problems | ☐ Kidney problems | ☐ Jaundice | ☐ Swollen Glands |
| ☐ Allergies | ☐ Cerebral palsy | ☐ Epilepsy | ☐ Low Blood Pressure | ☐ Prosthetic Joint | ☐ Thyroid Disease |
| ☐ Anemia | ☐ Chest pains | ☐ Emphysema | ☐ Muscular disorders | ☐ Pneumonia | ☐ Tuberculosis |
| ☐ Arthritis | ☐ Chronic neck pain | ☐ Fainting, Dizziness | ☐ Nervous Disorders | ☐ Rheumatic Fever | ☐ Venereal Disease |
| ☐ Asthma | ☐ Cold Sores/Herpes | ☐ Glaucoma | ☐ Organ Transplant | ☐ Scoliosis | ☐ |
| ☐ Autoimmune | ☐ Counseling | ☐ Heart Attack | ☐ Painful chewing | ☐ Seizures | |
| ☐ Bone Disorders | ☐ Diabetes | ☐ Headaches | ☐ Periodontal problems | ☐ Speech problems | |
| ☐ Bruise Easily | ☐ Downs Syndrome | ☐ Heart condition | ☐ Heart Surgery | ☐ Stroke | |
| ☐ Bulimia | ☐ Drug allergies | ☐ Hepatitis | ☐ Heart Murmur | ☐ Scarlet Fever | |
| ☐ Cardiac Pacemaker | ☐ Drug Dependency | ☐ High Blood Pressure | ☐ Hemophilia | ☐ Sickle Cell Disease | |

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

Current Medications? _____

Does the patient have any current finger or thumb sucking habits? Yes ☐ No ☐

Females: Are you currently pregnant? Yes ☐ No ☐

Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____

Are there any missing or extra teeth? _____ Have the Tonsils and adenoids been removed? _____

Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____

Does the patient have any problems with pain or clicking in the jaw joint? If yes please explain. _____

Are there any TMJ problems? If yes please explain. _____

Does the patient clinch or grind their teeth at night or during the day? If yes please specify. _____

***To the best of my knowledge, all of the preceding answers are true and correct.***
***If I ever have a change in my health, or if my medications change, I will inform Dr. West at my next appointment.***
***I understand that when appropriate, credit bureau reports may be obtained.***

Patient Or If Patient Is A Minor, Legal Guardian Signature: _____ Date: _____