Welcome

Welcome

We would like to welcome you and your family to our office. Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

801 Eastmont Avenue, Suite B, East Wenatchee, WA 98802 www.WenatcheeOrtho.com **509-886-4746**

All About You

Today's Date: _____

Legal Name: _____ **Preferred Name:** _____
First Last MI

Mr. ____ **Mrs.** ____ **Ms.** ____ **Dr.** ____ **Birthdate:** _____ **Age:** _____

Birth Sex: _____ **Hobbies:** _____

Cell #: _____ **Home #:** _____

Billing Address: _____

_____
City State Zip Code

E-Mail Address: _____

Employer: _____

How long there? _____ **Occupation:** _____

Marital Status - Single: ___ ***Married:*** ___ ***Partnered:*** ___ ***Divorced:*** ___ ***Widowed:*** ___ ***Separated:*** ___

Spouse / Partner's Name: _____ **Phone #:** _____

Additional Information

Whom may we thank for referring you?

Name: _____

Other family members seen by us: _____

_____

Emergency Contact

Name: _____ **Phone #:** _____

Address: _____

_____
City State Zip Code

Relation: _____

Primary Orthodontic Insurance

Orthodontic Coverage? **YES / NO**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

ID# / Social Security #: _____
(Required for orthodontic insurance verification only)

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

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

* **Merrill & Week Orthodontics is only contracted with state insured patients for craniofacial anomalies.**

Secondary Orthodontic Insurance

Orthodontic Coverage? **YES / NO**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

ID# / Social Security #: _____
(Required for orthodontic insurance verification only)

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

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

Medical History

Your current physical health is: GOOD FAIR POOR

Please list all medications that you are currently taking: _____

_____

_____

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 additional allergies: _____

_____

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

Y	N	Abnormal Bleeding	Y	N	Heart Murmur
Y	N	Anemia	Y	N	Heart Surgery / Pacemaker
Y	N	Artificial Bones / Joints / Valves	Y	N	Hemophilia
Y	N	Asthma	Y	N	Hepatitis
Y	N	Arthritis	Y	N	High / Low Blood Pressure
Y	N	Blood Transfusions	Y	N	HIV+ / AIDS
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Congenital Heart Defect	Y	N	Kidney Problems
Y	N	Diabetes	Y	N	Mitral Valve Prolapse
Y	N	Difficulty Breathing	Y	N	Mental Illness
Y	N	Drug / Alcohol Abuse	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy / Seizures	Y	N	Severe/ Frequent Headache
Y	N	Fainting	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Sexually Transmitted Disease
Y	N	Handicaps / Disabilities	Y	N	Tuberculosis (TB)
Y	N	Hearing Impairment	Y	N	Ulcers / Colitis
Y	N	Heart Attack / Stroke			

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

_____

_____

_____

Physician Name: _____

Phone #: _____ Date of last visit: _____

For Women:

Are you using a prescribed method of birth control? YES / NO

Are you pregnant? YES / NO Week #: _____

Are you nursing? YES / NO

Dental History

General Dentist: _____

Last Visit Date: _____

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

Have you ever had an injury to your: FACE MOUTH TEETH CHIN

Have adenoids or tonsils been removed? YES / NO

Do you have any missing or extra permanent teeth? 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 you brush your teeth daily? YES / NO

Floss teeth daily? YES / NO

Gums ever bleed? YES / NO

Do you have any speech problems? _____

Do you generally breathe through your mouth? YES / NO

If yes, please circle: While Awake? While Asleep?

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) YES / NO

Do you smoke or use Tobacco/Marijuana in any form? YES / NO

Have you ever experienced any of the following?

Y	N	Clenching / Grinding Teeth	Y	N	Speech Problems
Y	N	Snoring	Y	N	Nail Biting
Y	N	Thumb / Finger Sucking	Y	N	Tongue Thrust
Y	N	Lip Sucking / Biting	Y	N	Mouth Breather

- I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
- Our Privacy Policy is on our website: www.WenatcheeOrtho.com. If you would like a paper copy, please request one.
- The patient is responsible for payment.

_____ _____

Signature Date

Our office is HIPPA 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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I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Comments: _____

_____

Initials: _____ Date: _____