WELCOME TO Wortham Orthodontics

Our specialty is creating smiles and to do this we treat people, not just teeth. We care about your total health and appreciate your time in completing this form.

1 About you

Today's Date:_____ Nickname:_____

Name:_____ ☐ M ☐ F
LAST FIRST MI

Birthdate:____/____/____ Age:_____

Email:_____

Phone # we can text for appointment reminders:
(_____) _____

Cell provider (ie: Sprint, Verizon, ATT) _____

Home Address:_____

_____
CITY STATE ZIP

Whom may we thank for referring you?_____

List other family members seen by us:_____

2 Primary DENTAL Insurance

Orthodontic Coverage? ☐ Yes ☐ No

DENTAL Insurance Co. _____

Insurance Co. Phone # (_____) _____

Policy Owner's Name: _____

Policy Owner's Birthdate: ____/____/____

Member ID or SSN#_____

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

Relationship to Patient: _____

Policy Owner's Employer: _____

Policy Owner's Address (if different) _____

3 DENTAL History

What would you like orthodontic treatment to accomplish?

_____

_____

_____

Have you ever been evaluated or had orthodontic treatment before? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

Is there any type of thumb, finger or tongue habit? ☐Y ☐N

Are you aware of any jaw clicking or popping? ☐Y ☐N

Are you aware of any pain/tenderness in the jaw joint (TMJ/TMD)? ☐Y ☐N

Are you aware that some appointments will be during school/work hours? ☐Y ☐N

Dentist: _____

Phone # (_____) _____

4 Medical History

Have you ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergic to Latex / Metals	Y	N	Handicaps / Disabilities
Y	N	Allergic to Plastic	Y	N	Hearing Impairment
Y	N	Allergies to Any Drugs	Y	N	Heart Murmur
Y	N	Asthma	Y	N	Hemophilia
Y	N	Autism / Asperger's Syndrome	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV+ / AIDS
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)

Please list all medications that you are currently taking:

_____

Please list all medications / things that you are allergic to:

_____

Please explain any medical problems you have or anything that you circled YES to above:

_____

_____

_____

Physician: _____

Phone # (_____) _____

5

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

I authorize the dental staff to perform the necessary dental services that I may need.

_____
SIGNATURE OF PATIENT

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 confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____
SIGNATURE OF PATIENT DATE

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.

TFD 8346 TOPFORM DATA, INC. (800) 854-7470