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 the Patient

Today's Date:_____ Nickname:_____

Patient's Name:_____ ☐ M ☐ F
LAST FIRST MI

Birthdate:____/____/____ Age: _____

School:_____ Grade:____

Hobbies / Sports:_____

Who is responsible for making appointments?

Name: _____

Phone # we can text for appointment reminders:

(_____) _____

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

Patients Home Address _____

_____
CITY STATE ZIP

2 Primary Responsible Party

Primary Resp. Party:_____

DOB: _____ Relation to Patient _____

Address:_____

_____
City State Zip

Primary Phone: _____

Email:_____

Spouse/Partner Name:_____

Spouse/Partner Phone: _____

3 Secondary Responsible Party

***** Only if this is a SEPARATE HOUSEHOLD *****

Secondary Resp. Party: _____

DOB: _____ Relation to Patient _____

Address:_____

_____
City State Zip

Primary Phone: _____

Email:_____

Spouse/Partner Name:_____

Spouse/Partner Phone: _____

4 Who is Accompanying the Patient Today?

Name: _____ Relation:_____

Whom may we thank for referring you?_____

List other family members seen by us _____

_____

_____

Who is responsible for the account? _____

5 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) _____

Secondary 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) _____

CONTINUED ON BACK

Wortham Orthodontics

6 DENTAL History

What would you like orthodontic treatment to accomplish?

_____

_____

_____

Has the patient 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

Patient's Dentist: _____

Phone # (_____) _____

7 Medical History

Has the patient 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 the patient is currently taking:

_____

Please list all medications / things that the patient is allergic to:

_____

Please explain any medical problem that the patient has or anything that you circled YES to above:

_____

_____

_____

Patient's Physician: _____

Phone # (_____) _____

8

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 child's medical status.

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

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

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 deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

The Parent or Guardian who accompanies the child is responsible for payment.
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.