



James R. Wortham, DMD, MS  
Orthodontist

Welcome to our practice. 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 health history.

**PATIENT INFORMATION**

Name: _____			How did you hear about our office (Dentist, phone- book, friend, etc.)? _____
Last	First	Middle	
Nickname: _____ Male/ Female			_____
Birth date: _____ Age _____			Name of School/Occupation: _____
Address: _____			Grade/Position: _____
Street			What do you like to do (Hobbies, sports, music, etc)? _____
_____	_____	_____	_____
City	State	Zip	Siblings/children (name/age): _____
Home Phone: _____			_____
Cell Phone: _____			_____

**RESPONSIBLE PARTY**

<b>MOTHER'S NAME:</b> _____			<b>FATHER'S NAME:</b> _____		
Birth date: _____			Birth date: _____		
Address: _____			Address: _____		
Street			Street		
_____	_____	_____	_____	_____	_____
City	State	Zip	City	State	Zip
Home Phone: _____			Home Phone: _____		
Cell Phone: _____			Cell Phone: _____		
Email: _____			Email: _____		
Employer: _____			Employer: _____		
Work Phone: _____			Work Phone: _____		

**ORTHODONTIC INSURANCE**

<b>PRIMARY INSURANCE</b>		<b>SECONDARY INSURANCE</b>	
Insurance Co. Name: _____		Insurance Co. Name: _____	
Insurance Co. Phone: _____		Insurance Co. Phone: _____	
Policy Owner's Name: _____		Policy Owner's Name: _____	
Relationship to Patient: _____		Relationship to Patient: _____	
Birth date: ____ / ____ / ____ Group#: _____		Birth date: ____ / ____ / ____ Group#: _____	
Member ID or SS#: _____		Member ID or SS#: _____	
Policy owner's employer: _____		Policy owner's employer: _____	
_____		_____	

Making Smiles That Last a Lifetime!

**MEDICAL**

Have any of these conditions been present?

- YES NO Allergies to latex/metals
- YES NO Anemia
- YES NO Arthritis/Bone disorders
- YES NO Asthma
- YES NO Cancer/Tumor
- YES NO Congenital Heart defect
- YES NO Convulsions/Epilepsy
- YES NO Diabetes
- YES NO Handicaps/disabilities
- YES NO Heart murmur
- YES NO Hepatitis
- YES NO HIV+/AIDS
- YES NO Kidney/liver problems
- YES NO Nervous disorders
- YES NO Prolonged bleeding
- YES NO Thyroid problems
- YES NO Tuberculosis

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Please list any medications taken currently:

\_\_\_\_\_  
\_\_\_\_\_

Please list any known drug allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any other allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please discuss any medical conditions that were circled YES or any other conditions that you feel we should be aware of: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**DENTAL**

Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

What is your main concern with your teeth (spacing, crowding, etc.)? \_\_\_\_\_

YES  NO Do you like your smile? \_\_\_\_\_

What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

YES  NO Have you ever had trauma (accident) to face, mouth, or teeth? \_\_\_\_\_

YES  NO Do you have any type of thumb, finger or tongue habit? \_\_\_\_\_

YES  NO Have you ever seen an orthodontist? \_\_\_\_\_

YES  NO Has anyone in the family received orthodontic treatment? \_\_\_\_\_

How did they feel about the result? \_\_\_\_\_

YES  NO Are you aware of your jaw clicking or popping? \_\_\_\_\_

**BENEFITS OF ORTHODONTICS  
AESTHETICS, HEALTH AND FUNCTION**

Orthodontics is a service that provides an improvement in the appearance of the teeth, and in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases.

I hereby state that I have read and understand the above paragraph and that I have truthfully to the best of my ability answered all the above questions. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes.

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Date

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