Today's Date:

Please review and complete entire form and edit the information that was automatically entered for you.

## Patient Information

| Patient Name | |
|---|---|
| Nickname | |
| Gender | |
| Address | |
| Home/Work Phone | Home: Work: |
| Cell Phone | Cell: Cell Phone Carrier: |
| School | |

## Responsible Party Information

| First Responsible Party Name | |
|---|---|
| Relation to patient | □ Self □ Mother □ Father □ Step Parent □ Grandparent □Other ___ |
| Marital Status | □ Married □ Single □ Divorced Spouse's Name: |
| Financially Responsible for account? | □ Yes □ No |
| Address | |
| Primary Phone number | Secondary Phone: |
| Primary Resp. party Email (appt confirmation) | |

| Second Responsible Party Name | |
|---|---|
| Relation to patient | □ Self □ Mother □ Father □ Step Parent □ Grandparent □Other |
| Marital Status | □ Married □ Single □ Divorced Spouse's Name: |
| Financially Responsible for account? | □ Yes □ No |
| Address/Phone number | |
| Do you prefer text or Email reminders? | □Text □Email |
| By signing you are authorizing to receive confidential info via Email and or Text including appt reminders. | X<br>PLEASE SIGN |

**Wiewiora & Dunn Orthodontics will need to share information with your insurance company. For optimum care your information will be shared with your general dentist and other dental specialist(s), if needed, to facilitate treatment.**

Signature: ______________________________ Date: ____________________

Print Name: ______________________________ Relationship to patient: ____________

**HIPAA laws require our office to have authorization for whom we can release information regarding appointments, treatment and finances.**

List those who we may ***discuss treatment***: ____________________, ____________________, ____________________

List those who we may ***discuss financial information***: ____________________, ____________________, ____________________,

## Medical and Dental History

| Physicians Name | |
|---|---|

**Circle Yes or No to the questions asked below: (if yes, please fill in details)**

| | |
|---|---|
| Yes No Are you allergic to any medications?<br>Yes No Are you allergic to Nickel or Latex? | Name of medication(s)_______________________________________________<br>List other allergies:_______________________________________________ |
| Yes No Do you have a history of a major illness? | Yes No Have your tonsils or adenoids been removed? |
| Yes No Have you had any major operations? | Yes No Have you ever been involved in a serious accident? |
| ***List medications currently taking & dosage:*** | |
| | |

**Circle** any of the medical conditions below that you ***have had*** or ***currently have***. **Is *medication needed prior* to dental procedures? Y / N**

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Congenital Heart Defect | | |
| ADD/ADHD | Diabetes | Hepatitis /Liver Problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation / Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV or AIDS | Rheumatic Fever |
| Autism | Heart Problems | Kidney Problems | Tuberculosis |
| Bone Disorders | Heart Murmur | Nervous Disorders | Tumor or Cancer |
| | | | |
| **Are there any other medical issues or conditions that we should know about?** | | | |
| | | | |

| **Dental History** | | |
|---|---|---|
| **Dentist:** | | **Date of Last Visit:** |
| Do you go for regular dental check-ups? | | |
| What concerns you most about your teeth? | | |
| **Circle Yes or No to the questions asked below: (if Yes, please fill in details)** | | **Details** |
| Yes No | Are you presently in any dental pain? | ___________________ |
| Yes No | Have you ever experienced any unfavorable reaction to dentistry? | |
| Yes No | Have you ever lost or chipped any teeth? | |
| Yes No | Have there been any injuries to face, mouth or teeth? | |
| Yes No | Is any part of your mouth sensitive to temperature or pressure? | |
| Yes No | Do your gums bleed when you brush? | |
| Yes No | Do you have any type of thumb or tongue habit? Any other oral habit? | |
| Yes No | Are you a mouth breather? | |
| Yes No | Have you ever seen an orthodontist? | |
| Yes No | Has anyone in your family received orthodontic treatment? | |
| | How did they feel about the result? | |
| | What is your attitude toward receiving orthodontic treatment? | |
| Yes No | Are you aware of your jaw clicking or popping? Any jaw pain? | |
| Yes No | Do your teeth or jaws ever feel uncomfortable when you awake in the morning? | |
| Yes No | Are you aware of clenching your teeth during the day? | |
| Yes No | Have you ever been told that you grind your teeth? | |
| Yes No | Do you have "tension" headaches? | |
| Yes No | Have you ever experienced chronic ringing in your ears? | |
| Yes No | Are you aware that some appointments will be during school/work hours? | |

### Benefits of Orthodontics Aesthetics, Health, and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, 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 swollen gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment.

***Our office releases health information to the patient/parents insurance company, general dentist, and other dental specialists (if needed) to facilitate your treatment***. _____________ (initial)

If insurance benefits are available and there is a balance on the account any and all insurance payments will be applied to the balance. In the event that an insurance payment is received and the account has a $0 (zero) balance a refund will be issued to the subscriber of the insurance coverage.

I have read and understand the above paragraphs. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in medical or dental history. I have received, read and understand my Health Information (HIPAA) rights.

Signature: _______________________________________ Patient/Guardian Date___________________

Print Name: ______________________________________ Relationship to Patient: __________________

# How Did You Hear About Us

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know all the ways you heard about our office. Put a check next to each source that applies then circle the *main* reason you selected our office and bring this to your appointment.
Thank you!

_____DENTIST

_____FAMILY MEMBER / SIBLING

_____FRIENDS / CO-WORKERS

_____BUILDING SIGN / LOCATION

_____YELLOW PAGE LISTING

_____SCHOOL ADVERTISMENT

_____AUCTION CERTIFICATE

_____INTERNET SEARCH / WEBSITE

_____INSURANCE CO. / NETWORK PROVIDER LIST

_____INVISALIGN PROVIDER LIST

_____ONE OF DR.WIEWIORA / DR. DUNN EMPLOYEES

_____SPORTS TEAMS / SPONSORSHIP

_____FLORIDA BARTER REFERRAL

_____CMS / CLEFT PALATE TEAM REFERRAL

_____SCHOOL EDUCATION PROGRAMS

_____OTHER, PLEASE SPECIFY____________________

Please list all of your friends that referred you here so we may thank them properly.

______________________________________________________________________________

______________________________________________________________________________