

**PLEASE PRINT**

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex M  F  Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**\* This is the person who will be responsible for payments. If the patient does not live with the responsible party, permission must be obtained from the responsible party before treatment begins.**

Does Patient Live With This Person? Y  N  SSN \_\_\_\_\_ -- \_\_\_\_ -- \_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Primary's Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email address \_\_\_\_\_

Secondary Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Does Patient Live With This Person? Y  N

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Secondary Party's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Who can we contact in case of emergency? Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Relationship \_\_\_\_\_

Do you have insurance with Orthodontic benefits? Yes  No

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Holder \_\_\_\_\_ S.S.N \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

By signing below, you allow Dr. Wittenberger's office to submit claims and receive payments on your behalf.

\_\_\_\_\_  
Signature

**GENERAL MEDICAL HISTORY**

- AIDS/HIV
- Dizziness
- Rheumatic Fever
- Allergies
- Fainting
- Sore throats
- Bleeding (prolonged)

- Arthritis
- Heart Problems
- Tuberculosis
- Blood Transfusions
- Herpes (fever blisters)
- Hepatitis HBV
- Adenoids Removed

- Breathing Problems
- Polio
- Convulsions
- Psychiatric Counseling
- Diabetes
- Repeated Headache

Any recent head or neck trauma? Yes  No  If yes, explain \_\_\_\_\_

TMJ (jaw joint) problems? Yes  No  If yes, explain \_\_\_\_\_

List Current Medications \_\_\_\_\_

Is there a need for pre medication before treatment? Yes  No

Who can we thank for referring you to our office?(i.e. yellow pages, friend/family) \_\_\_\_\_  
 Name of your General Dentist \_\_\_\_\_  
 Last date of your dental exam/cleaning? \_\_\_\_\_  
 Why are you looking for Orthodontic care? \_\_\_\_\_

**DENTAL HISTORY**

- Yes  No Have you previously had any orthodontic treatment?
- 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?
- Yes  No Are you a mouth breather?
- Yes  No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
- Yes  No Are you aware of your jaw clicking or popping?
- 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 Are you aware that some appointments will be during school/work hours?

**Female Patients only:**

- Yes  No Are you pregnant?

**BENEFITS**

**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. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Wittenberger to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ON OCCASION WE POST PICTURES AND ARTICLES OF PATIENTS IN OUR OFFICE FOR RECOGNITION OF SUPER PATIENT OR EXTRACURRICULAR ACTIVITIES. DO WE HAVE PERMISSION TO POST A PICTURE OR A NEWSPAPER CLIPPING OF YOU OR YOUR CHILD?**  YES  NO

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_