



Walker Orthodontics

Leah M. Walker, DDS, MS

Smiles Made Here

Date _____

No. **PATIENT INFORMATION**

Patient's Name _____ Date of Birth _____ Age _____
First Last

Preferred Name (Nick Name) _____ Female Male School _____ Grade _____

Home Phone _____ Cell Phone _____

Alternate Phone _____ Family Dentist _____ Last Seen _____

Address _____

If patient is a minor, who is legal guardian Relationship to Patient _____ Who may we thank for referring you _____

PARENTS INFORMATION

FATHER

Name _____ Marital Status _____
First Last

Residence _____
Street Number Street Suite/Apt City ZIP

Mailing Address _____
(If Different than residence) Street Number Street Suite/Apt City ZIP

Home Phone _____ Cell Phone _____

Email _____ Employer's Name _____

MOTHER

Name _____ Marital Status _____
First Last

Residence _____
Street Number Street Suite/Apt City ZIP

Mailing Address _____
(If Different than residence) Street Number Street Suite/Apt City ZIP

Home Phone _____ Cell Phone _____

Email _____ Employer's Name _____

INSURANCE

PRIMARY

Insurance Co _____ Tel _____

Subscriber Name _____ DOB _____

Subscriber ID#/SSN# _____ Group Name/# _____

SECONDARY

Insurance Co _____ Tel _____

Subscriber Name _____ DOB _____

Subscriber ID#/SSN# _____ Group Name/# _____

IN CASE OF EMERGENCY

Please Contact _____ Tel _____
(nearest relative not living with you) First Last

Address _____
Street Suite/Apt City ZIP

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due to me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

Signature of Responsible Party



MEDICAL HISTORY

Patient's Physician _____ Date of Last Visit _____ Patient in good health? No Yes

Patient's Height _____ Patient's Expected Height _____ Mother's Height _____ Father's Height _____

Has the patient experienced any of the following:

- Headache Problems No Yes
Sinus / Ear / Nose / Throat Problems No Yes
Eye / Glaucoma / Dizziness Problems No Yes
Muscle / Neural Problems No Yes
Bone / Artificial Joint Problems No Yes
Hormonal Problems No Yes
Blood / Prolonged Bleeding Problems No Yes
Epilepsy / Seizure / Fainting Problems No Yes
Urinary / Liver / Stomach Problems No Yes
Learning / Psychiatric Problems No Yes
Head / Neck / Back Problems No Yes

For all yes answers please provide specifics below:

- Specifics: _____
Specifics: _____
Specifics: _____
Specifics: _____
Specifics: _____
Specifics: _____
Specifics: _____
Specifics: _____

Allergies: Metal Latex Drugs (please list) _____
 Plastics Foods (please list) _____
 Dental Anesthetics Other (please list) _____

Table with 4 columns: Childhood Diseases, Heart Problems, Breathing Problems, Chronic Diseases. Includes checkboxes for conditions like Tonsils Removed, Murmur, Asthma, Tuberculosis, etc.

List any medications now being taken: _____
Have you ever taken Fosamax, Acetenol, Boniva, Aredia, Zometa, bisphosphonates, or any other bone medications? No Yes
Children: Regarding puberty . . . If female, has menstruation started? If male, has voice changed? No Yes When? _____
Female Adults Only. Are you currently pregnant? No Yes Birth Control? No Yes
Do you smoke? No Yes If so how much / day? _____
Any other health problems, surgeries, etc. ? _____

DENTAL HISTORY

Family Dentist _____ Date of Last Visit _____ Yearly Checkups? One Two Never

Jaw or Face Injury / Trauma -> No Yes -> Broken Jaw -> Other (Explain) _____
Tooth Injury / Trauma -> No Yes -> Broken -> Chipped _____
Oral Habits (pacifier, etc.) -> No Yes -> Thumb Sucking -> Other: _____ Until Age: _____
Mouth Problems -> No Yes -> Mouth Breathing -> Tongue Thrust Grinding / Clenching _____
Bleeding Gums -> No Yes -> After Brushing -> After Flossing All Times _____
Ever Had Speech Therapy? -> No Yes -> Advised By: _____ For: _____
Jaw Joint Pain -> No Yes -> Explain: _____
Jaw Joint Popping / Clicking -> No Yes -> Both Sides Right Side Left Side _____
Other Dental Problems -> No Yes -> Explain: _____

Have you been evaluated for orthodontic treatment before? No Yes Have you had problems with previous dental work? No Yes
How do you feel about braces? _____
What are you most excited about changing in your smile? _____
Questions for Dr. Walker? _____

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing information I have given on this form is correct and that I am obligated to inform Dr. Walker immediately if any of this information changes in the future.

Signature of Patient or Guardian _____
Patient Name: _____ if patient is a minor: _____

Doctors Comments: