Walker 3D Orthodontics

Leah M. Walker, DDS, MS

Smiles Made Here

Date _____

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____
First Last

Preferred Name (Nick Name) _____ ❑ Male ❑ Female Age _____

Address _____
Street Number Street Suite/Apt City Zip

Home Phone _____ Cell Phone _____

Preferred Communication: ❑ Email ❑ Text ❑ Home ❑ Cell Dentist _____

Who may we thank for referring you _____ Marital Status _____

Email _____ Employer's Name _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____
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 _____

Name _____ Relationship to Patient _____
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

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MEDICAL HISTORY

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

Patient's Height _____

Has the patient experienced any of the following:			*For all yes answers please provide specifics below:*
Headache Problems	❑ No	❑ Yes	Specifics: _____
Sinus / Ear / Nose / Throat Problems	❑ No	❑ Yes	Specifics: _____
Eye / Glaucoma / Dizziness Problems	❑ No	❑ Yes	Specifics: _____
Muscle / Neural Problems	❑ No	❑ Yes	Specifics: _____
Bone / Artificial Joint Problems	❑ No	❑ Yes	Specifics: _____
Hormonal Problems	❑ No	❑ Yes	Specifics: _____
Blood / Prolonged Bleeding Problems	❑ No	❑ Yes	Specifics: _____
Epilepsy / Seizure / Fainting Problems	❑ No	❑ Yes	Specifics: _____
Urinary / Liver / Stomach Problems	❑ No	❑ Yes	Specifics: _____
Learning / Psychiatric Problems	❑ No	❑ Yes	Specifics: _____
Head / Neck / Back Problems	❑ No	❑ Yes	Specifics: _____

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

Childhood Diseases	*Heart Problems*		*Breathing Problems*	*Chronic Diseases*	
❑ Tonsils Removed	❑ Murmur	❑ Poor Blood Pressure	❑ Asthma	❑ Tuberculosis	❑ Cancer
❑ Mumps / Measles	❑ Chest Pain	❑ Heart Valve Problem	❑ Hay Fever	❑ Hepatitis	❑ Radiation
❑ Rheumatic Fever	❑ Angina	❑ Heart Failure / Attack	❑ Wheezing	❑ Diabetes	❑ Chemotherapy
❑ Chicken Pox	❑ Palpations	❑ Coronary Disease	❑ Chronic Cough	❑ HIV / AIDS	

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.

Patient Name: _____ Signature of Patient _____

Doctors Comments: