Walker 3D Orthodontics

Leah M. Walker, DDS, MS

Smiles Made Here

Date ____________________

No. PATIENT INFORMATION

Patient's Name ______________ (First) ______________ (Last) Date of Birth ____________ Age ______

Preferred Name (Nick Name) ____________________ ❑ Female ❑ Male School ______________ Grade ______

Address ______ (Street Number) ______ (Street) ______ (Suite/Apt) ______ (City) ______ (ZIP)

Home Phone ____________________ Cell Phone ____________________

Preferred Communication: ❑ Email ❑ Text ❑ Home ❑ Cell Family Dentist ______________ Last Seen ______

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

PARENTS' INFORMATION

FATHER

Name ______________ (First) ______________ (Last) Marital Status ______________

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 ______________ (First) ______________ (Last) Marital Status ______________

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 (nearest relative not living with you) ______________ (First) ______________ (Last) Tel ______________

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 ________ Patient's Expected Height ________ Mother's Height ________ Father'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 or Guardian if patient is a minor: ________________

Patient/Guardian Update: ________________ Date: ________
Patient/Guardian Update: ________________ Date: ________