WOLFE ORTHODONTICS

Sara Wolfe, D.D.S., M.S.D.

Orthodontics East

Patient's Full Name _____ Preferred Name_____

Mailing Address_____ City _____ Zip_____

Home Phone_____ Gender _____Date of birth_____ School_____Grade____

Patient resides with: ☐ Mother ☐ Father ☐ Both ☐ Other_____

Patient email address _____

Referred by _____ Do you know a patient currently in our practice? Whom _____

Describe the orthodontic problem in your own words: _____

Parent's Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

| | FATHER | MOTHER |
|---|---|---|
| Name | _____ | _____ |
| Date of Birth | _____ | _____ |
| Address (if different from above) | _____ | _____ |
| | _____ | _____ |
| Cell Phone Number | _____ | _____ |
| Social Security Number | _____ | _____ |
| Employer's Name | _____ | _____ |
| Business Phone | _____ | _____ |
| Occupation | _____ | _____ |
| Email Address | _____ | _____ |

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and ***the patient or person responsible for the account is responsible for payment of all fees incurred.*** For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

**Primary Insurance**

Name of insured (Employee) _____ DOB_____

Insurance Co._____ Ins. Phone # _____

Cardholder's Address _____

Group # _____ ID#_____ Social Security # _____

Employer_____

**Secondary Insurance**

Name of insured (Employee) _____ DOB_____

Insurance Co. _____ Ins. Phone # _____

Cardholder's Address _____

Group # _____ ID#_____Social Security # _____

Employer_____

Physician's Name_____ Phone_____

Is your child currently under physician's care? ☐ No ☐ Yes Explain:_____
Is your child currently taking medications? ☐ No ☐ Yes List:_____

Is your child allergic to any medications? ☐ No ☐ Yes List:_____
**Is your child allergic to latex or metals?** ☐ No ☐ Yes List:_____

| | | | | | |
|---|---|---|---|---|---|
| Heart Murmur | ☐ No ☐ Yes | Hepatitis | ☐ No ☐ Yes | Emotional Problems | ☐ No ☐ Yes |
| Heart Surgery | ☐ No ☐ Yes | Diabetes | ☐ No ☐ Yes | Frequent Headaches | ☐ No ☐ Yes |
| Rheumatic Fever | ☐ No ☐ Yes | Kidney Disease | ☐ No ☐ Yes | Nervous/Anxious | ☐ No ☐ Yes |
| Endocrine Disorders | ☐ No ☐ Yes | Liver Disease | ☐ No ☐ Yes | Cancer | ☐ No ☐ Yes |
| Prolonged Bleeding | ☐ No ☐ Yes | Tuberculosis | ☐ No ☐ Yes | Bone Disorders | ☐ No ☐ Yes |
| Anemia | ☐ No ☐ Yes | Bronchitis | ☐ No ☐ Yes | Growth Disorders | ☐ No ☐ yes |
| Blood Disease | ☐ No ☐ Yes | Asthma | ☐ No ☐ Yes | AIDS | ☐ No ☐ Yes |
| Developmental Disorder | ☐ No ☐ Yes | Epilepsy | ☐ No ☐ Yes | Herpes(fever blisters) | ☐ No ☐ Yes |
| Hives/Rash | ☐ No ☐ Yes | Fainting | ☐ No ☐ Yes | Tonsillitis | ☐ No ☐ Yes |

Is there any other condition(s) or concerns that you think we should know about?_____

**Growth Information for Patients Under 16 Years of Age**
Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has your son or daughter reached puberty? ☐ No ☐ Yes
Do you feel growth is completed? ☐ No ☐ Yes
Height:_____ Weight:_____

**Dentist's Name:**_____
**Phone**_____
**Company Name:** _____ **City**_____

Have either siblings or parents had orthodontic treatment? ☐ No ☐ Yes With whom?_____
Has your child had any previous orthodontic treatment? ☐ No ☐ Yes With whom?_____
Has your child consulted an orthodontist previously? ☐ No ☐ Yes With whom?_____
Were records or x-rays taken at the orthodontic's office? ☐ No ☐ Yes Date of x-rays:_____
(If an x-ray is needed for this exam we will not be able to file insurance if another doctor has filed for the same x-ray)

Frequency of dental checkups: Twice a year ☐ Once a year ☐ Only if a problem exist ☐ Never ☐ Date of last visit:_____
Were x-rays taken with in the last year by the dentist? ☐ No ☐ Yes
Is there any unfinished care needed with your child's dentist? ☐ No ☐ Yes Explain:_____
Has your child had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain:_____
Has your child had any injuries to the face or teeth? ☐ No ☐ Yes Explain:_____
Does your child play any musical instruments? ☐ No ☐ Yes What instrument?_____
Does your child play sports? ☐ No ☐ Yes Which sports?_____
Does your child wear a mouth guard while playing sports? ☐ No ☐ Yes
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes
Has your child's tonsils or adenoids been removed? ☐ No ☐ Yes Age Removed:_____
Is there a history of thumb, finger or tongue sucking? ☐ No ☐ Yes Has habit stopped? ☐ No ☐ Yes

_____
Please check if there is a history of:

| | | | |
|---|---|---|---|
| ☐ Clenching teeth | ☐ Muscular soreness around head & neck | ☐ Jaw/joint soreness | ☐ Jaw/joint popping or clicking |
| ☐ Grinding teeth | ☐ Headaches (more than normal) | ☐ Excessive snoring | ☐ Ringing in the ears |
| ☐ Speech problems | ☐ Mouth breathing: Awake_____ Asleep_____ | | |

**I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes to this record, I will inform this practice. I also agree to pay all monies due under the signed contract and any amount that is unpaid by the insurance company or insurance companies, that I have provided for Sara Wolfe DDS., MSD.'s office to file.**

_____ _____ _____
**Parent's signature** **Date** **Reviewed by:**

**For Doctor Use Only:** **PREMEDICATE FOR BANDING / DEBANDING** ☐ **YES** ☐ **NO**