Windermere
ORTHODONTICS
& Pediatric Dentistry

Welcome! We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

*Required Fields

*Patient Name:_____SS# (21 & up) _____
Last First

*Sex (Circle One) M / F *Age:_____ *Birth Date_____/_____/_____

*Address (If different from drivers license) _____

*City:_____ *State:_____ *Zip:_____

*Home Ph:_____ Alternate Phone (Circle one: Work / Cell) _____

*E-Mail_____

*Marital Status (Circle one) Single Married Widowed Separated Divorced

Whom may we thank for referring you?_____

*Notify in case of emergency:_____ *Emergency contact #_____

*Person responsible for account:_____ *Relation to patient_____

*Responsible party birth date:_____/_____/_____ *SS#:_____*Phone#_____

Address (if different from patient)_____

Responsible party employed by:_____ Occupation_____

*Dentist:_____ Date of last visit:_____

What concerns do you have about your smile?_____

Please continue on the next page

DENTAL HISTORY

Check if you have/had any of the following:

☐ Bad Breath	☐ Food collecting between teeth	☐ Periodontal treatment	☐ Prior dental trauma
☐ Bleeding Gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold/hot	☐ Finger /Tongue Habit
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity when biting	☐ Prior Orthodontic treatment

How often do you brush? _____ **Floss?** _____

How do you feel about the appearance of your smile?_____

Have you ever experienced any adverse reactions during or in conjunction with a medical procedure? ☐ **Y** ☐ **N**

If yes, please explain:_____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Y ☐ N

Physician's Name:_____ **Phone:**_____

Have you ever had a blood transfusion? ☐ **Y** ☐ **N** **Have you ever taken Fen-Phen/Redux** ☐ **Y** ☐ **N**

Women: Are you pregnant? ☐ **Y** ☐ **N** **Nursing?** ☐ **Y** ☐ **N** **Taking birth control?** ☐ **Y** ☐ **N**

Check if you have had any of the following:

☐ AIDS/HIV Positive	☐ Circulatory Problems	☐ Hemophilia/abnormal bleeding	☐ Pacemaker/Heart Surgery	☐ Surgical Implant
☐ Anaphylaxis	☐ Cortisone Treatment	☐ Herpes	☐ Psychiatric Care	☐ Swelling of feet or ankles
☐ Arthritis/Rheumatism	☐ Cough, persistent	☐ Hepatitis	☐ Rheumatic/Scarlet fever	☐ Venereal Disease
☐ Artificial heart valve	☐ Coughing up blood	☐ High Blood Pressure	☐ Shingles	☐ Other:
☐ Artificial Joints	☐ Diabetes	☐ Jaw pain	☐ Shortness of breath	Describe_____
☐ Asthma	☐ Epilepsy	☐ Kidney disease/malfunction	☐ Skin Rash	
☐ Atopic (allergy prone)	☐ Fainting	☐ Liver disease	☐ Spina Bifida	
☐ Autism	☐ Food Allergies	☐ Material Allergies (LATEX, wool, metal)	☐ Stroke	
☐ Back problems	☐ Glaucoma	☐ Mitral valve prolapsed	☐ Thyroid disease or malfunction	
☐ Blood disease	☐ Headaches	☐ Nervous problems	☐ Tobacco Habit	
☐ Cancer	☐ Heart Murmur	☐ Rapid weight loss/gain	☐ Tonsillitis	
☐ Chemical dependency	☐ Heart Problems	☐ Radiation treatment	☐ Tuberculosis	
☐ Chemotherapy	Describe:_____	☐ Respiratory disease	☐ Ulcer/Colitis	

Is patient currently taking any medications? If yes, list all:_____

Does Patient have drug allergies? If yes, list all:_____

Authorization:
I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the Orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the Orthodontist.

I authorize the insurance company indicated on the form to pay Windermere Orthodontics & Pediatric Dentistry all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature:_____ **Date:**_____