

BRIAN A. WOMBLE, D.M.D.

PERSONAL INFORMATION

Patient's Name: _____ Preferred Name: _____ Sex: ___ Birth Date: _____

Home Address: _____ City & Zip: _____

Home Phone: _____ General Dentist Name: _____

Information For Patients Who Are Minors:

School: _____ Grade: _____

Father

Mother

Name: _____

Address & Phone _____

(if different from above) _____

Employer's Name: _____

Business Phone: _____

Occupation: _____

Parent's Marital Status Married Separated Divorced Widowed

Information For Adult Patients:

Business Address: _____ Business Phone: _____

Occupation: _____ Marital Status: _____

Name of Spouse: _____ Spouse's Occupation: _____

Person Responsible For Payment Of Account: _____

Is Patient Covered By Orthodontic Insurance? Yes No

Name Of Orthodontic Insurance Company? _____

MEDICAL HISTORY

Is patient in good health? Yes No Reason if No: _____

Any major or unusual illnesses? Yes No If Yes, Explain: _____

Currently under physician's care? Yes No If Yes, Explain: _____

Allergies Yes No If Yes, List: _____

Drug Sensitivity Yes No If Yes, List: _____

Please check if patient has or had any of the following:

- Yes No Yes No Yes No
 Anemia Heart Disease Frequent colds or flu
 Blood Disease Tuberculosis Tonsillitis
 Prolonged Bleeding Diabetes Adenitis
 Hepatitis Endocrine Problems Tonsils removed: Age: _____
 Aids or in risk category Bone disorders Adenoids removed: Age: _____
 Jaundice Epilepsy Asthma
 Rheumatic fever Herpes Mouth breathing

Growth Information For Patients Under 16 Years of Age:

Father's Height: _____ Mother's Height: _____ Adopted? Yes No

Patient resembles: Neither Parent Mother Father

Girls: Has patient started menstruation? Yes No When? _____

Boys: Has patient's voice changed? Yes No When? _____

Names and ages of patient's brothers and sisters: _____

Have any siblings had orthodontic treatment? Yes No When? _____

DENTAL HISTORY

Yes No Has the patient had any severe head or face injuries? Explain: _____

Has the patient had a history of thumb sucking or finger sucking? _____

Does the patient play any musical (wind) instrument? What? _____

Has the patient consulted an orthodontist previously? When? _____

Has the patient had any previous orthodontic treatment? When? _____

Please check if there is a history of:

Clenching teeth Headaches (more than normal) Jaw joint popping

Grinding teeth Jaw joint soreness Ringing in the ears

Muscular soreness Jaw joint clicking

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

Parent Signature (if patient is a minor)

Date

Patient Signature (if adult)

Date