Questionnaire

Printed On: 2/27/20

Patient Registration

Patient Registration

WOW Orthodontics
Dr. Wendy Oakes

Patient Registration

Patient First Name
Patient Last Name
Preferred Name
Date of Birth
SSN
Gender
Male Female
Address
City
State
Zip
Home Phone
Cell Phone
Email
Who may we thank for referring you to our office?
General Dentist
Have you ever had orthodontic treatment?
Yes No
Family members who have had orthodontic treatment
What would you like to accomplish with orthodontic treatment?
Patients attitude/feelings toward treatment?
Hobbies/Sports
School Name (if applicable)

Emergency Contact

Emergency Contact Name
Relationship to Patient
Emergency Contact Phone Number

Responsible Party (if patient has responsible party)

Responsible Party First Name
Date of Birth
Responsible Party Last Name
SSN
Gender
Male Female
Marital Status

Home Phone

Cell Phone

Work Phone

Email

Street Address

City

State

Zip

Relationship to Patient

Second Responsible Party

Full Name

Date of Birth

SSN

Gender

Marital Status

Home Phone

Cell Phone

Work Phone

Email

Address

City

State

Zip

Relationship To Parent

Health History

Health History (Please select all that apply)

Latex allergy	Bone disorder	Mitral valve prolapse
Diabetes	Liver problems	Emotional problems
Joint prosthesis	Anemia	Arthritis
Heart trouble	Rheumatic fever	Hepatitis
Brain injury	Kidney problems	Tuberculosis
Epilepsy	Prolonged bleeding	Adenoids removed
Tonsillitis	AIDS or HIV	Faintness/Dizziness
Endocrine problems	Nervous disorders	Hearing disorder
Tonsil removed	Sore throat	Earaches
Asthma	Ringing ears	Pneumonia
High blood pressure	Reached puberty	None

Major/Minor Surgery

List Any Allergies

List Any Serious Illnesses

List ALL medications, OTC, herbal supplements you take currently:

Have any members of your family had Rheumatoid Arthritis?

Dental History

Dental History (Please select all that apply)

Thumb, finger, lip sucking?	Extra permanent teeth	Difficult to chew/swallow
Mouth breathing when awake	Pain/clicking when opening	Frequent headaches
Missing permanent teeth	Teeth removed by extraction	Tongue thrust problem
Mouth breathing when asleep	Clenching/grinding teeth	None

Any injuries to face, mouth, or teeth?

How many headaches per week

Muscle tenderness or stiffness in the jaw or neck?

More than average amount of tooth decay?

Insurance Information

Subscriber's Full Name

Subscriber's DOB

Relationship to Patient

Employer

SSN

Group Number

Insurance Company:

Insurance Phone:

Insurance Address: