W | O

WILKINSON ORTHODONTICS

David A. Wilkinson, D.D.S., M.S.D

Welcome to our Office!
PATIENT INFORMATION: **DATE:** _____

Last **First** **Middle**

Nickname: _____ □ Male □ Female Date of Birth: _____/_____/_____ Age: _____

Address: _____
City State Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Other family members seen in our office, and their relationship to the patient: _____

Dentist name:_____ Last seen: _____

How did you hear about us? **Dentist** **Insurance** **Web** **Phone book** **Advertisement** **Friend**

Has an orthodontic treatment been consulted previously? _____

RESPONSIBILITY PARTY INFORMATION: ***MUST BE COMPLETED*** **Circle One**

SELF *FATHER* *MOTHER* *STEP FATHER/ MOTHER* *GRANDPARENT* *GUARDIAN*

_____
Last First Middle Date of Birth

Mailing Address:_____

How long at this address _____

Previous Address (if less than 3 years)_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email: _____ **Social Security #**:_____

Employer: _____ **Occupation**:_____ No. Years Employed: _____

IF MARRIED, ENTER SPOUSES INFORMATION:

_____
Last First Middle Date of Birth

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email: _____ **Social Security #**:_____

Employer: _____ **Occupation**:_____ No. Years Employed: _____

EMERGENCY INFORMATION:

Name of nearest relative not living with you: _____ Relationship with Patient: _____

Phone #:_____

6820 OAK HILL BLVD., TYLER, TEXAS 75703 Phone (903) 597-6372 Fax (903) 592-8482

DENTAL ASSESSMENT/HISTORY:

Antibiotics required prior to dental visits? □ Yes □ No If Yes, explain: _____

_____

Has the patient has any of the following dental problems? (Please circle Yes or No

Jaw Joint Pain/Tenderness	YES	NO	Tooth/Jaw Trauma	YES	NO
Does your jaw joint make noise?	YES	NO			
Do you grind your teeth at night?	YES	NO	Does your jaw lock open?	YES	NO
Lip/Tongue Biting	YES	NO	Do you clench your teeth?	YES	NO
Missing Permanent Teeth	YES	NO	Tongue Thrust	YES	NO
Allergy to Dental Anesthetics	YES	NO	Extra Permanent Teeth	YES	NO

Have you ever been examined or treated for a TMD problem? Yes No When & By Whom? _____

What was the treatment? (Please mark below)

___ Bite Splint ___Medication ___Physical Therapy ___Occlussal Adjustment ___Orthodontics ___Surgery

Other (Please Explain)_____

MEDICAL ASSESSEMENT/HISTORY: Patient's Physician: _____ Last Visit: _____

Does the patient have current or previous history of the following conditions? **(Please circle Yes or No)**

Abnormal Bleeding	YES	NO	Heart Problems	YES	NO	Diabetes	YES	NO
Plastic/Metal Allergy	YES	NO	Cancer or Tumor	YES	NO	Asthma	YES	NO
Rheumatic Fever	YES	NO	Fainting or Dizziness	YES	NO	Hepatitis	YES	NO
Epilepsy/Convulsions	YES	NO	Anemia	YES	NO	Hemophilia	YES	NO
Thyroid Problems	YES	NO	High Blood Pressure	YES	NO	Tuberculosis	YES	NO
Tonsils/Adenoids Problems	YES	NO	Hearing Impairment	YES	NO	Mouth Breathing	YES	NO
Kidney/Liver Problems	YES	NO	Chronic Sinus/Allergies	YES	NO	HIV+/AIDS	YES	NO
Difficulty Swallowing	YES	NO	Fever Blisters	YES	NO	Tobacco Use	YES	NO
Chronic Headaches	YES	NO	Gastrointestinal	YES	NO	Pregnant Now	YES	NO
Other Disabilities	YES	NO						

Please explain any previous, or ongoing, medical conditions, problems, surgeries, etc.:

_____

_____

List any medications being taken, and their purpose: _____

_____

Please list any allergies to medications:_____

AFFIRMATION: I affirm that the information that I have given is correct to the best of my knowledge. The information will be held in the strictest confidence. It is my responsibility to inform this office immediately of any changes in financial, medical and/ or insurance status.
I certify that I am or my child, is covered by the above-listed insurance and assign all insurance benefits directly to Dr. David Wilkinson, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits, and the use of this signature on all insurance submissions, whether manual or electronic.

_____ _____

Signature of Responsibility Party ***Date***

Primary Dental Insurance: Orthodontic Coverage? Yes No

Policy Holders Name:_____ Date of Birth:_____

Relationship to Patient:_____

Insurance Company Name:_____ Phone #:_____

Employer Name:_____

ID # (or SS#):_____ Group #:_____