JOSHUA GREEN DMD

PATIENT INFORMATION FORM

Patient Details

Patient's First Name: Bruce | Patient's Last Name: Wayne | Nickname: Batman

Patient's Address: 123 Gotham drive | City: Gotham | State: UT | Zip: 84444

Interests/Sports/Hobbies: | Gender: Male | Home Phone: (123) 456-7888

Date of Birth: 03/14/1989 | Age: 30y 0m | Race: White | Cell Phone: (123) 489-7899

School/Employer: Wayne Industries | Grade/Position: Owner/CEO | Work Phone: (651) 498-1968

How did you hear about our office: The penguin | Patient's Email: darknight@batman.com

Family members treated in our office: none :(

Reason for consultation: Punched by joker in mouth

Dentist: Dr. Strange | Date of last cleaning: 03/06/2019

Has the patient been examined by an orthodontist before? ☑ Yes ☐ No

Guardian #1 / Insurance Information

☑ Self ☐ Spouse ☐ Father ☐ Mother ☐ Stepparent ☐ Other (specify)

Guardian's First Name: Bruce | Guardian's Last Name: Wayne | Home Phone: (123) 456-7888

Address: 123 Gotham drive | City: Gotham | State: UT | Zip: 84444

Employer: Wayne Industries | Work Phone: (651) 498-1968

Date of Birth: 03/14/1989 | Social Security Number: 658-98-1968 | Cell Phone: (123) 489-7899

OTHER INSURANCE (IF APPLICABLE): | Guardian's E-Mail: darknight@batman.com

Company Name: Crane Insurances | Phone: (698) 168-9819 | Subscriber/Member ID: 5584

Guardian #2 / Insurance Information

☑ Self ☐ Spouse ☐ Father ☐ Mother ☐ Stepparent ☐ Other (specify)

Guardian's First Name: | Guardian's Last Name: | Home Phone:

Address: | City: | State: | Zip:

Employer: | Work Phone:

Date of Birth: | Social Security Number: | Cell Phone:

OTHER INSURANCE (IF APPLICABLE): | Guardian's E-Mail:

Company Name: | Phone: | Subscriber/Member ID:

Sleep Airway Issues

Does the patient tend to be a mouthbreather? ☑ Yes ☐ No

Does the patent seem rested in the morning? ☑ Yes ☐ No

Has the patient seen an Ear, Nose & Throat Specialist? ☑ Yes ☐ No

Does the patient snore at night? ☐ Yes ☑ No

Is the patient often sleepy during the day? ☐ Yes ☑ No

Is the patient using a sleep apnea device? ☐ Yes ☑ No

Dental/Medical History

Please check if the patient has a history of the following medical conditions:

☐ Yes	☑ No	ADHD/ADD	☑ Yes	☐ No	Diabetes	☑ Yes	☐ No	Low Blood Pressure
☑ Yes	☐ No	AIDS/HIV	☑ Yes	☐ No	Down Syndrome	☐ Yes	☑ No	Muscular Disorders
☑ Yes	☐ No	Acid Reflux	☐ Yes	☑ No	Ear Pain	☑ Yes	☐ No	Nervous Disorders
☐ Yes	☑ No	Anemia	☑ Yes	☐ No	Emotional Disorders	☐ Yes	☑ No	Organ Transplant
☑ Yes	☐ No	Arthritis	☐ Yes	☑ No	Endocrine Problems	☑ Yes	☐ No	Osteoporosis
☐ Yes	☑ No	Asthma	☐ Yes	☑ No	Epilepsy	☐ Yes	☑ No	Painful Chewing
☑ Yes	☐ No	Autism	☑ Yes	☐ No	Headaches	☑ Yes	☐ No	Periodontal Problems
☐ Yes	☑ No	Bone Disorders	☐ Yes	☑ No	Heart Condition	☐ Yes	☑ No	Prolonged Bleeding
☑ Yes	☐ No	Cancer	☑ Yes	☐ No	Hepatitis	☑ Yes	☐ No	Rheumatic Fever
☐ Yes	☑ No	Cerebral Palsy	☑ Yes	☐ No	Immune Problems	☐ Yes	☑ No	Scoliosis
☑ Yes	☐ No	Chest Pain	☑ Yes	☐ No	Jaw Clicking	☑ Yes	☐ No	Seizures
☐ Yes	☑ No	Chronic Neck Pain	☐ Yes	☐ No	Jaw Pain	☐ Yes	☑ No	Sinus Problems
☐ Yes	☑ No	Cold Sores/Herpes	☐ Yes	☑ No	Kidney Problems	☑ Yes	☐ No	TMJ Problems
						☐ Yes	☐ No	Tuberculosis

☐ Yes	☑ No	Do your gums bleed when you brush?	
☑ Yes	☐ No	Is the patient seeing any other dental specialists (e.g., periodontist)?	Periodontist
☑ Yes	☐ No	Any dental restorations needing to be completed? What?	root canal
☑ Yes	☐ No	Have there ever been any injuries to the face, mouth or chin?	lots of fighting crime
☑ Yes	☐ No	Have you ever lost or chipped any teeth? Which tooth/teeth?	most of them
☑ Yes	☐ No	Do you have any pain or soreness around your face, neck or back?	lots of punches to the face
☑ Yes	☐ No	Is any part of your mouth sensitive to temperature or pressure?	bottom right sensitive to hot
☑ Yes	☐ No	Is the patient currently pregnant? Due Date?	03-15-2020
☑ Yes	☐ No	Have adenoids been removed? If yes, when?	2 years ago
☑ Yes	☐ No	Have tonsils been removed? If yes, when?	8 years ago
☑ Yes	☐ No	Currently taking any medications? List.	antibiotics
☑ Yes	☐ No	Are antibiotics necessary prior to treatment? List.	my medications
☑ Yes	☐ No	Allergies (i.e., Drug, Latex, etc.)	latex
☐ Yes	☑ No	Any diseases or problems not mentioned above? List here.	

Please check if the patient has, or ever had, any of the following habits?

☑ Cheek, tongue or lip chewing	☐ Clenching teeth	☑ Finger nail biting	☐ Grinding teeth
☑ Tongue sucking	☐ Thumb sucking	☑ Tongue thrusting	

Signed Consent

I understand the information given is correct and will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in the patient's medical status.

I hereby authorize this office to perform an orthodontic evaluation and consent to the taking of x-rays, photographs, and other records (if necessary) to determine appropriate treatment on the above-named patient.

I also authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

Typed Name/Signature: Bruce Wayne Relationship to Patient: Self Date: 03/14/2019

If someone other than the parent(s) or guardian(s) listed above will be bringing the patient to appointments, please list here:

Alfred Pennyworth