PATIENT INFORMATION FORM

PATIENT DETAILS

Patient's First Name: Bruce | Patient's Last Name: Wayne | Nickname: Dark Knight

Patient's Address: 1007 Mountain Drive | City: Gothem | State: UT | Zip: 84003

Interests/Sports/Hobbies: | Gender: Male | Home Phone: (801) 326-5987

Date of Birth: 04/07/1989 | Age: 30y 1m | Race: White | Cell Phone: (801) 326-5987

School/Employer: Wayne Industries | Grade/Position: CEO/Owner | Work Phone: (800) 232-6566

How did you hear about our office: co-worker | Patient's Email: darknight@batman.com

Family members treated in our office: Alfred

Reason for consultation: Tooth Ache

Dentist: Dr. Chase Meridian | Date of last cleaning: 04/03/2019

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: (801) 326-5987

Address: 1007 Mountain Drive | City: Gothem | State: UT | Zip: 84003

Employer: Wayne Industries | Work Phone: (800) 232-6566

Date of Birth: 04/07/1989 | Social Security Number: 989-84-4611 | Cell Phone: (801) 326-5987

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

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

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?	back molar
☑ Yes	☐ No	Have there ever been any injuries to the face, mouth or chin?	lots of fighting
☑ Yes	☐ No	Have you ever lost or chipped any teeth? Which tooth/teeth?	two front top teeth
☑ Yes	☐ No	Do you have any pain or soreness around your face, neck or back?	back was broken a while ago, still have pain after healing.
☑ Yes	☐ No	Is any part of your mouth sensitive to temperature or pressure?	front teeth sensitive to cold
☐ Yes	☑ No	Is the patient currently pregnant? Due Date?	
☑ Yes	☐ No	Have adenoids been removed? If yes, when?	1995
☑ Yes	☐ No	Have tonsils been removed? If yes, when?	1996
☐ Yes	☑ No	Currently taking any medications? List.	
☐ Yes	☑ No	Are antibiotics necessary prior to treatment? List.	
☐ Yes	☑ No	Allergies (i.e., Drug, Latex, etc.)	
☐ 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: 06/03/2019

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

Alfred