WISE LEE ORTHODONTICS

Frisco
6960 Parkwood Blvd., Ste 100
Frisco, TX 75034

McKinney
3109 Custer Road, Ste 100
McKinney, TX 75070

972-712-6862 | www.WiseLeeOrtho.com

UPDATE: ____________________

patient information

PATIENT NAME .... LAST .... FIRST .... MIDDLE .... NICKNAME

PRIMARY PHONE .... BIRTH DATE .... GENDER M / F

PRIMARY EMAIL ....

IF PATIENT IS A MINOR, WHO DOES THE PATIENT PRIMARILY LIVE WITH? ....

PATIENTS CHIEF COMPLAINT ....

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ....

SCHOOL ATTENDING ....

SIBLING/CHILDREN INFORMATION:

NAME .... DOB .... SEX M / F NAME .... DOB .... SEX M / F

NAME .... DOB .... SEX M / F NAME .... DOB .... SEX M / F

responsible party

RESPONSIBLE PARTY 1: SELF FATHER MOTHER OTHER MARITAL STATUS ....

NAME .... EMAIL ....

ADDRESS .... STREET .... CITY .... STATE .... ZIP RENT/OWN # OF YRS AT ADDRESS? ....

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) .... STREET .... CITY .... STATE .... ZIP

PHONE (home) .... (work) .... (cell) ....

EMPLOYER .... OCCUPATION .... # YRS EMPLOYED ....

SOCIAL SECURITY # .... BIRTHDATE ....

RESPONSIBLE PARTY 2: SPOUSE FATHER MOTHER OTHER MARITAL STATUS ....

NAME .... EMAIL ....

ADDRESS (IF DIFFERENT FROM ABOVE) .... STREET .... CITY .... STATE .... ZIP RENT/OWN # OF YRS AT ADDRESS? ....

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) .... STREET .... CITY .... STATE .... ZIP

PHONE (home) .... (work) .... (cell) ....

EMPLOYER .... OCCUPATION .... # YRS EMPLOYED ....

SOCIAL SECURITY # .... BIRTHDATE ....

dental insurance information

INSURED'S NAME .... RELATIONSHIP TO PATIENT ....

INSURANCE COMPANY .... GROUP # .... MEMBER ID # ....

INSURANCE CO. ADDRESS .... INSURED'S EMPLOYER ....

emergency information

EMERGENCY CONTACT (not living with you) .... RELATIONSHIP .... PHONE ....

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PARENT'S SIGNATURE IF MINOR) .... **DATE** ....

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MEDICAL AND DENTAL HISTORY FORM

Your answers are for office records only and are confidential.

DENTAL HISTORY

Dentist Name: ______________________ City: ______________ Last Visit: __________

Is any Dental work pending? ______________ Please describe: ______________________

History of dental visits (Circle One): 1 x year 2 x year 3 or more x year Emergency Only

How often do you brush per day (Circle One): 1x 2x 3+ How often do you floss per week (Circle One): Rarely Daily 2-3x

Any chewing difficulties? Y / N If Yes, please describe: ______________________

Jaw Joints that: Click (L / R) Pop (L / R) Grind (L / N)

Who suggested that you might need orthodontic treatment? ______________________

Why did you select our office? ______________________

Have you had any previous orthodontic treatment? Y / N If yes, please describe: ______________________

Have any other family members been treated in this office? Y / N Please name them: ______________________

NOW OR IN THE PAST, HAS THE PATIENT HAD: MARK AN "X" FOR ALL THAT APPLY AND CIRCLE AS NEEDED

- ☐ Started teething very early or late
- ☐ Primary (baby) teeth removed that were not loose
- ☐ Supernumerary (Extra), missing or impacted teeth
- ☐ Chipped or injured primary (baby) or permanent teeth
- ☐ Teeth sensitive or sore
- ☐ Bleeding gums, bad taste, or mouth odor
- ☐ Lost or broken fillings
- ☐ Jaw fractures, cysts, infections
- ☐ Teeth treated with root canals or pulpotomies
- ☐ Frequent canker sores or cold sores
- ☐ Speech problems or speech therapy
- ☐ Difficulty breathing through nose
- ☐ Food impaction between teeth
- ☐ Mouth breathing habit or snoring at night
- ☐ Abnormal swallowing habit (tongue thrusting)
- ☐ Frequent oral habits (sucking finger, chewing pen, etc.)
- ☐ Teeth causing irritation to lips, cheeks or gums
- ☐ Tooth grinding or clenching
- ☐ Difficulty in chewing or opening jaw
- ☐ Soreness in jaw muscles or face muscles
- ☐ Ringing in ears
- ☐ Treated for "TMJ" or "TMD" problems
- ☐ Trouble associated with any previous dental treatment
- ☐ Gum Disease
- ☐ Orthodontic consultation or treatment before now
- ☐ Premedicate for any dental procedures

MEDICAL HISTORY:

Patient's Current Physical Health? Excellent ______ Good ______ Fair ______ Poor ______

Patient's Physician ______________________ City ______________

Last Seen ______________________ Reason ______________

Other physicians/healthcare providers being seen now: (ENT, Allergist, Neurologist - for example)

Name ______________________ City ______________ Reason ______________

Name ______________________ City ______________ Reason ______________

List any prescription medication, nutritional supplements, herbal or non-prescription medicines, including fluoride supplements, that you take.

Item: ______________________ Taken for ______________________

Item: ______________________ Taken for ______________________

Have you ever had a substance abuse problem? ______________ Chew or smoke tobacco? ______________

Have you noticed any changes in your face or jaws? Please describe ______________________

Any other physical problems? ______________________

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant?: ☐ Yes ☐ No

Have your parents or siblings ever had any of the following health problems? Mark an "x" for all that apply

☐ Bleeding Disorders ☐ Diabetes ☐ Arthritis ☐Severe Allergies

☐ Unusual dental problems ☐ Jaw size imbalance ☐ Other family medical conditions: ______________________

Please explain: ______________________

NOW OR IN THE PAST, HAS THE PATIENT HAD: MARK AN "X" FOR ALL THAT APPLY

☐ Birth defects or hereditary problems
☐ Injuries to face, head, neck
☐ Endocrine or thyroid problems
☐ Diabetes or low sugar
☐ Immune system problems
☐ Polio, mononucleosis, tuberculosis or pneumonia
☐ Osteoporosis
☐ Hepatitis, jaundice, or liver problem
☐ Mental health disturbance or behavioral problem
☐ History of eating disorder (anorexia, bulimia)
☐ High or low blood pressure
☐ Heart defects, heart murmur rheumatic heart disease
☐ Skin disorder
☐ Frequent ear infections, colds or sore throats
☐ Frequently breathe through the mouth
☐ Sleep Disorder
☐ Bone fractures, any major accidents
☐ Arthritis or joint problems
☐ Kidney problems
☐ Cancer, tumor, radiation treatment or chemotherapy
☐ Stomach ulcer or hyperacidity
☐ AIDS or HIV positive
☐ Sexually transmitted diseases
☐ Fainting spells, seizures, epilepsy, or neurological problem
☐ Vision, hearing, tasting or speech difficulties
☐ Excessive bleeding or bruising tendency, anemia, or bleeding disorder
☐ Chest pain, shortness of breath or swelling ankles
☐ Angina, arteriosclerosis, stroke, or heart attack
☐ Special diet, please describe: ______________________
☐ Frequent headaches or migraines
☐ Hayfever, asthma, sinus trouble or hives
☐ Cardiovascular problems If yes, please explain ______________________

Has the patient ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia(pamidronate) or Didronel (etidronate) for bone disorders or cancer? ☐ Yes ☐ No ☐ Not sure

Has the patient ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders? ☐ Yes ☐ No ☐ Not sure

Has the patient had allergies or reactions to any of the following? Mark an "x" for all that apply

☐ Latex (gloves, balloons) ☐ Acrylics ☐ Metals (jewelry, clothing snaps)
☐ Animals ☐ Plant pollens ☐ Foods
☐ Penicillin ☐ Aspirin ☐ Ibuprofen (Motrin, Advil)
☐ Other antibiotics ______________________ ☐ Other substances______________________

Airway History: Mark an "x" for all that apply and circle as needed

☐ Snoring while sleeping (daily, weekly, rarely)
☐ Trouble breathing during sleep
☐ Bed wetting (daily, weekly, rarely)
☐ Hard to wake up
☐ Morning headaches
☐ Autism / Autism Spectrum Disorder
☐ Mouth breathing: Sleep / Awake
☐ Sleepy during the day
☐ Enlarged: Tonsils / Adenoids
☐ Removed: Tonsils / Adenoids
☐ ADHD/ADD Diagnosis

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Patient/Guardian Signature ______________________ Date ______________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my or my child's medical or dental health.

Patient/Guardian Signature ______________________ Date ______________________

MEDICAL HISTORY UPDATES

Changes ______________________

Patient/Guardian Signature______________________ Date______________________

Dental Staff Signature______________________ Date______________________

Changes ______________________

Patient/Guardian Signature______________________ Date______________________

Dental Staff Signature______________________ Date______________________