

Welcome to Volovic Orthodontics!

Date _____

Patient's name _____

Last

First

Middle

Nickname

Address _____

Street

City

State

Zip Code

Cell Phone _____

Email address _____

Birth date _____

Who may we thank for referring you to our office? _____

I WOULD LIKE TO RECEIVE APPOINTMENT CONFIRMATION BY (please circle) TEXT yes no EMAIL yes no

I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand I can withdraw my consent at any time. My cell phone number is _____ (include area code) _____ (initial)

Responsible Party Information

Parent's marital status: Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐

Father's name _____

Last

First

Middle

Address (If different from patient) _____

Street

City

State

Zip code

Home Phone (If different from patient) _____

Work/Cell Phone _____

Employer _____

Number of year's employed _____

Mother's name _____

Last

First

Middle

Address (If different from patient) _____

Street

City

State

Zip code

Home phone (If different from patient) _____

Work/ Cell Phone _____

Employer _____

Number of year's employed _____

Who is responsible for this account? _____

Who is responsible for making appointments? _____

Primary Orthodontic Insurance Information

Insured's name _____

Insured's ID Number _____

Insured's birth date _____

Insurance Company _____

Insurance Co. Address _____

Insurance Co. Phone _____

Medical History

Physician's name _____ Phone number _____

Please describe patient's current physical health: Good ☐ Fair ☐ Poor ☐

Is patient currently under the care of a physician? Yes ☐ No ☐

If yes, for what condition: _____

Please list all medications patient is currently taking: _____

Please list all medications patient is allergic to: _____

Has patient ever been hospitalized? For what reason? _____

Has patient ever had any of the following medical problems?

Adverse reaction to any medications	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy/Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
AIDS/HIV+	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent sore throats	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please list _____		Heart disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial valves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma/Hay fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	High/low blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral valve prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy/Radiation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital heart defects	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsils or adenoids removed	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dizziness/Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema/Difficulty breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Female patients:

Have you started your menstrual cycle? Yes ☐ No ☐ Date of first menstruation _____
(This helps Dr. Wittler determine the amount of growth remaining.)

Are you currently taking birth control pills Yes ☐ No ☐ (Some antibiotics block the effectiveness of these medications.)

Are you currently pregnant? Yes ☐ No ☐ (We don't take X-rays on patients who are or may be pregnant.)

Dental History

Dentist's name _____ Date of last visit _____

What are the main concerns that orthodontic treatment should accomplish? _____

Is this your first orthodontic exam?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Has patient ever had any of the following habits?	
Does patient like his/her smile?	Yes <input type="checkbox"/> No <input type="checkbox"/>	(If habit stopped, please indicate when)	
Has there ever been injury to the face		Clenching or grinding teeth.	Yes <input type="checkbox"/> No <input type="checkbox"/>
mouth, teeth, or chin?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lip sucking or biting	Yes <input type="checkbox"/> No <input type="checkbox"/>
-Explain please _____			
Has there ever been pain, tenderness,		Mouth breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>
clicking, or popping in the jaw joint?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nail biting	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has there ever been difficulty in chewing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do patient's gums ever bleed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tongue thrust	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has patient ever been diagnosed with		Thumb or finger sucking	Yes <input type="checkbox"/> No <input type="checkbox"/>
periodontal disease ?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

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

Signature: _____ Date: _____