

Patient Information

Patient's Name _____
First Middle Last

Age _____ Birthdate _____ E-Mail Address _____

By What Name Does The Patient Prefer To Be Called? _____ Cell Phone (_____) _____

Home Address _____ Home Phone(_____) _____
Number Street City State Zip Code

Social Security # _____ Sex _____ Marital Status _____

Patient's Occupation _____
Length Of Employment

Employer / School _____ Work Phone (_____) _____

Hobbies/Musical Instruments _____

Responsible Party Information (If Patient Is A Minor)

Father's Name Rev Dr Mr _____ Marital Status _____
First Last

Employer _____ Occupation _____
Length Of Employment

Work Phone(_____) _____ Social Security # _____

Home Address _____ Home Phone(_____) _____
Number Street City State Zip Code

E-Mail Address _____ Cell Phone (_____) _____

Mother's Name Rev Dr Ms Mrs _____ Marital Status _____
First Last

Employer _____ Occupation _____
Length Of Employment

Work Phone(_____) _____ Social Security # _____

Home Address _____ Home Phone(_____) _____
Number Street City State Zip Code

E-Mail Address _____ Cell Phone (_____) _____

Primary Dental Insurance

If you have orthodontic insurance, please complete the following **AND** allow us to make a copy of your card.

Subscriber _____ Relationship to patient _____
 D.O.B. _____ Social Security # _____
 Employer _____ ID Number on Card _____
 Insurance Company _____ Group Number _____
 Address _____ Phone Number (_____) _____

Secondary Dental Insurance

Subscriber _____ Relationship to patient _____
 D.O.B. _____ Social Security # _____
 Employer _____ ID Number on Card _____
 Insurance Company _____ Group Number _____
 Address _____ Phone Number (_____) _____

Medical Information

Patient's primary physician _____

Please check appropriate answer to the following questions. Your answers are confidential and for our records only.

Are you taking any medications at this time? If yes, please list below: Yes No
Taking _____ for _____ taking _____ for _____
Taking _____ for _____ taking _____ for _____

Do you require premedication with antibiotics prior to dental procedures? _____

Do you have any allergies or drug sensitivities? If yes, please list _____

Are you allergic to latex - such as balloons or gloves? _____

Have you ever or do you currently smoke? _____

Have you ever had or been treated for any of the following conditions or diseases?

Check any boxes below that apply. If yes, please explain.

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma Or Hay Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pregnant At This Time |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hepatitis - Specify Type _____ | <input type="checkbox"/> Do You Or Have You Ever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV + Aids | Taken A Bisphosphonate |
| <input type="checkbox"/> Diverticulitis/Colitis | <input type="checkbox"/> Kidney/Bladder Infection | Drug Such As: |
| <input type="checkbox"/> Dizziness Or Fainting | <input type="checkbox"/> Malignancies (Cancer) | Pamidronate (Aredia), |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Mononucleosis | Zoledronate (Zometa), |
| | <input type="checkbox"/> Thyroid Or Parathyroid Disorders | Alendronate (Fosamax)? |
| | | <input type="checkbox"/> Other _____ |

Please Check Box If None Of The Above Apply.

Explanation Of "Yes" Responses: _____

Yes No

Any Other Condition Or Problem Which We Should Be Aware Of? _____

Dental Information

Patient's dentist _____

Additional specialists seen _____ For what reason _____

Check any boxes below that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Face, Mouth or Teeth Injury | <input type="checkbox"/> Speech Impairments | <input type="checkbox"/> Stiff Neck Muscles |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Sucked Finger Or Thumb | <input type="checkbox"/> Clenching Of Teeth |
| <input type="checkbox"/> Mouth Breathing | Until What Age _____ | <input type="checkbox"/> Grinding Of Teeth |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Loss Of Permanent Teeth | <input type="checkbox"/> Clicking Or Popping Of The Jaw |
| <input type="checkbox"/> Removal Of Tonsils | <input type="checkbox"/> Growths Or Swelling | <input type="checkbox"/> Difficulty Opening Mouth Wide |
| <input type="checkbox"/> Removal Of Adenoids | In Mouth | <input type="checkbox"/> Headaches - How Often _____ |
| <input type="checkbox"/> Difficulty Chewing Or Swallowing | <input type="checkbox"/> Bleeding Gums | |
| | <input type="checkbox"/> Food Frequently Lodged In | |
| | Between Teeth | |

Please check box if none of the above apply.

Explanation of "yes" responses: _____

Orthodontic Information

What is the primary concern? _____

Has the patient had previous orthodontic consultations or treatments? _____ Yes No

If yes, when _____ by whom _____

Other children in the family? If yes, what are their ages _____

Has any one in the family had orthodontic treatment? _____

Names treated _____ by whom _____

Emergency Information

Name of nearest relative not living with you _____
name relationship

Address _____ phone number(_____) _____
number street city state zip code

How did you hear about our office?

- Friend _____ Website / Internet _____
 Dentist _____ Yellow Pages _____
 Other _____

Do you realize that appointments will infringe on school/work time? _____

The information given on this form is accurate to the best of my knowledge. I hereby give my consent to perform the necessary diagnostic tests (including x-rays) to adequately evaluate my/the patient's dental health. I also understand that where appropriate, credit bureau reports may be obtained. In addition, I understand that my electronic protected health information may be used by personnel in this office in connection with my treatment, payment of my account, or in contact with my insurance company or other health care providers as outlined in the office privacy practices.

Signature of patient, parent or guardian

date

The doctors of Sawyer Creek Orthodontics, S.C. believe that certification, accreditations and teaching are important attributes to belonging to professional organizations. By signing below, I give consent to Sawyer Creek Orthodontics to use my records for these purposes. (It should be noted that all personal information would be held in confidence.)

Signature of patient, parent or guardian

date

6 Month Interval Updates

Initials

date

Initials

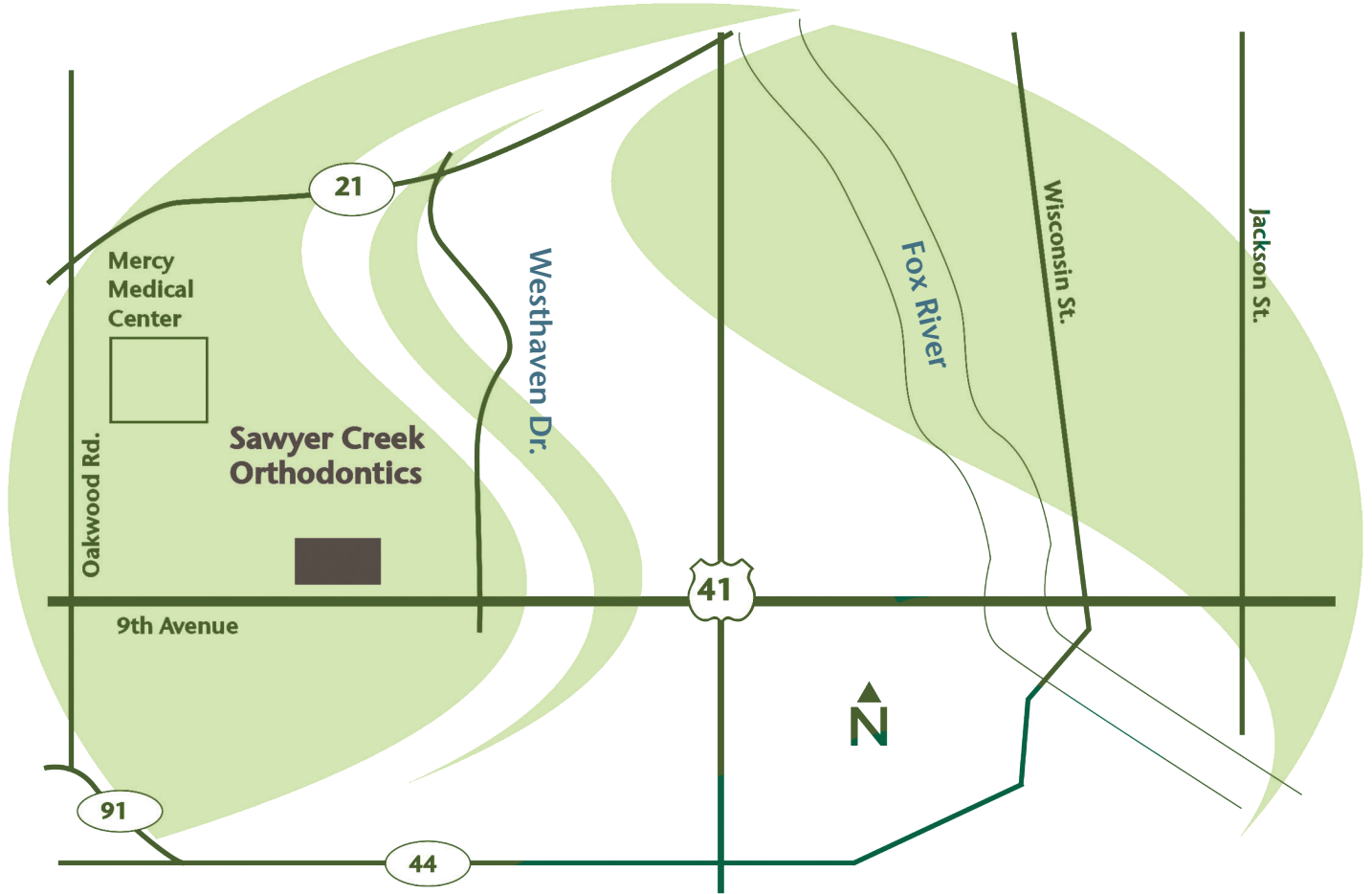
date

Initials

date

Initials

date



Sawyer Creek Orthodontics, S.C.

2626 W. 9th Avenue | Oshkosh, WI
920-231-4922

N2888 State Road 22 | Wautoma, WI
920-231-4922

322 Broadway St. | Berlin, WI
920-290-3259

www.sawycreekortho.com