NEW PATIENT INFORMATION

WEST ORTHODONTICS

Please Completely Fill in All Information

Office Use Only
Stat File Scan

Patients Preferred Name: _____ Email Address: _____

Patients Address: _____ Telephone: _____ Cell Phone: _____

Birth date: _____ Age: _____ Male: _____ Female: _____

School/Employer: _____ Grade/Position: _____

Interest/Sports: _____

Self *or Primary Responsible Party*

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Name: _____ Telephone: _____ Cell Phone: _____

Address: _____ **Years At This Address?** _____ **Own** ☐ **Rent** ☐

Employer: _____ Occupation: _____ Years Employed? _____

Social Security Number: _____ Date of Birth: _____

Marital Status: **Married** ☐ **Single** ☐ **Divorced** ☐

Spouse *or Secondary Responsible Party*

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Name: _____ Telephone: _____ Cell Phone: _____

Address: _____ **Years At This Address?** _____ **Own** ☐ **Rent** ☐

Employer: _____ Occupation: _____ Years Employed? _____

Social Security Number: _____ Date of Birth: _____

Marital Status: **Married** ☐ **Single** ☐ **Divorced** ☐

In case of an emergency, whom shall we contact?
(Please list someone other than above)

Name: _____ Relationship: _____ Address: _____

Primary Phone: _____ Secondary Phone: _____

How Did You Hear About Us? ☐ My Dentist ☐ Patient Of Dr. West ☐ Relative ☐ Acquaintance ☐ Other _____

Please List Name(s) Of Referral Source(s) so we may thank them: _____

Please List relatives or close friends seen in our office: _____

Current Dentist: _____ Last Visit : _____ Reason For Visit? _____

Reason For Considering Orthodontics: _____

Has An Orthodontist Been Consulted Previously? _____ If Yes Please List Name Of Orthodontist: _____

Have you had previous orthodontic treatment? _____ If Yes Please List Name Of Orthodontist: _____

What is the patient's attitude toward wearing braces if necessary? Eager ☐ Willing ☐ Will, if they have to ☐ Against ☐

Insurance Information *(Please fill out completely so we may properly file your insurance)*

Name of Primary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Policy Holders Date Of Birth: _____ Social Security Number: _____

Insurance ID Number: _____ Group Number: _____

Name of Secondary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Policy Holders Date Of Birth: _____ Social Security Number: _____

Insurance ID Number: _____ Group Number: _____

Please provide your insurance card(s) to be copied at the front desk.

Remember insurance is not a substitute for payment. We request that charges for office visits be paid at the conclusion of each visit.

I herby authorize payment directly to Lance E. West DMD MS PC. I also authorize "signature on file" to be used on insurance forms.

Signature of Responsible Party: _____ Relationship To Patient: _____ Date: _____

Health History *Check box for which the patient has a history:*

☐ AIDS	☐ Cardiac Pacemaker	☐ Drug Dependency	☐ High Blood Pressure	☐ Hemophilia	☐ Sickle Cell Disease
☐ Alcohol Dependency	☐ Chemotherapy	☐ Emotional disorders	☐ Hay Fever	☐ Hypoglycemia	☐ Sinus Trouble
☐ Allergies	☐ Cancer	☐ Endocrine problems	☐ Kidney problems	☐ Jaundice	☐ Swollen Glands
☐ Anemia	☐ Cerebral palsy	☐ Epilepsy	☐ Low Blood Pressure	☐ Prosthetic Joint	☐ Thyroid Disease
☐ Arthritis	☐ Chest pains	☐ Emphysema	☐ Muscular disorders	☐ Pneumonia	☐ Tuberculosis
☐ Aspirin	☐ Chronic neck pain	☐ Fainting, Dizziness	☐ Nervous Disorders	☐ Rheumatic Fever	☐ Venereal Disease
☐ Asthma	☐ Cold Sores/Herpes	☐ Glaucoma	☐ Organ Transplant	☐ Scoliosis	
☐ Autoimmune	☐ Counseling	☐ Heart Attack	☐ Painful chewing	☐ Seizures	
☐ Bone Disorders	☐ Diabetes	☐ Headaches	☐ Periodontal problems	☐ Speech problems	
☐ Bruise Easily	☐ Downs Syndrome	☐ Heart condition	☐ Heart Surgery	☐ Stroke	
☐ Bulimia	☐ Drug allergies	☐ Hepatitis	☐ Heart Murmur	☐ Scarlet Fever	

Any disease, problems, or allergies not mentioned above? _____

Current Medications? _____

Females: Have you started Menstruating? _____ At what age? _____

Females: Are you currently pregnant? Yes ☐ No ☐

Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____

Are there any missing or extra teeth? _____ Have the Tonsils and adenoids been removed? _____

Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____

Does the patient have any problems with pain or clicking in the jaw joint? If yes please explain: _____

Are there any TMJ problems? If yes please explain: _____

Does the patient clinch or grind their teeth at night or during the day? If yes please specify: _____

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have a change in my health, or if my medications change, I will inform Dr. West at my next appointment.
I understand that when appropriate, credit bureau reports may be obtained.

Patient or if patient is a minor, Legal Guardian Signature: _____ Date: _____