WOODVIEW
orthodontic specialists

1401 MERCANTILE LANE, SUITE 102
LARGO, MD 20774
301-773-7703

Confidental responsible party information

Name: ______ Last ______ First ______ Middle ______ Marital Status: ______

Residence: ______ Street ______ City ______ State ______ Zip

Mailing Address: ______ Street ______ City ______ State ______ Zip

How long at this address: ______ Home Phone: ______ Work Phone: ______ Cell Phone: ______

Previous Address (if less than 3 years): ______ Street ______ City ______ State ______ Zip

Social Security #: ______ Birthdate: ______ Relationship to the Patient: ______

Employer: ______ Occupation: ______ No. Years Employed: ______

Spouse's Name: ______ Last ______ First ______ Middle ______ Relationship to the Patient: ______

Spouse Employer: ______ Occupation: ______

Spouse Social Security #: ______ Spouse Birthdate: ______ Spouse Work Phone: ______

Confidental patient information

Patient Name: ______ Last ______ First ______ Middle

Address: ______ Street ______ City ______ State ______ Zip

Home Phone: ______ Birthdate: ______ Social Security #: ______

If patient is a minor, give parent's or guardian's name: ______

Whom may we thank for referring you to our office?: ______

Insurance Inforamtion

**Complete or provide your insurance card to copy for your file.*

Policy Holder Name: ______

Birthdate: ______ SSN: ______

Insurance Co. Name: ______

Group #: ______ Union Local #: ______

Insurance Co. Address: ______

______

Insurance Co. Phone #: ______

Policy Holder's Employer: ______

Do you have dual coverage?: ☐ No ☐ Yes ... If yes:

Policy Holder's Name: ______

Birthdate: ______ SSN: ______

Insurance Co. Name: ______

Group #: ______ Union Local #: ______

Insurance Co. Address: ______

______

Insurance Co. Phone #: ______

Policy Holder's Employer: ______

Emergency Inforamtion

Name of nearest relative not living with you: ______

Complete Address: ______ Street ______ City ______ State ______ Zip

Phone: ______ Relationship: ______

I authorize this office to release any information necessary to submit and expedite insurance claims. I understand that I am responsible for all costs of orthodontic treatment, regardless of insurance coverage. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor): ______ Date: ______

Updates (date & initial): ______

Please continue on the back side

Patient Medical History

1. Are you in good health? ☐ No ☐ Yes
2. Are you under the care of a physician? ☐ No ☐ Yes

   If yes. what condition: ____________________

3. Are you currently taking any medications? ☐ No ☐ Yes

   If yes, please list medications: ____________________

4. Do you have or have you had any of the following problems or diseases? (check box if yes) ☐ No

   ☐ Heart Murmur - If yes, do you take medication prior to dental appointment?
   ☐ Heart Problem
   ☐ Hepatitis, Jaundice or Liver Disease
   ☐ Asthma or Hay Fever
   ☐ Diabetes
   ☐ Aids
   ☐ Other ____________________

5. Are you allergic to any drugs/medications (such as penicillin, codeine, aspirin) or have a latex allergy? ☐ No ☐ Yes

   If yes. what are you allergic to?: ____________________

6. Do you have any disease, condition or other problems not listed that you think we should know about? ☐ No ☐ Yes

   If yes, describe: ____________________

Patient Dental History

1. Do you have any pending dental work? ☐ No ☐ Yes

   If yes, what: ____________________

2. When was your last dental check-up? ____________________
3. When was your last dental cleaning? ____________________
4. Have you ever had any abnormal bleeding associated with previous extractions, surgery or trauma? ☐ No ☐ Yes
5. Do your gums bleed? ☐ No ☐ Yes
6. Are you aware of grinding or clenching your teeth? ☐ No ☐ Yes
7. Have there been any injuries to face, mouth or teeth? ☐ No ☐ Yes
8. Do you have any speech problems? ☐ No ☐ Yes
9. Have you ever been told of any missing or extra permanent teeth? ☐ No ☐ Yes
10. Do you experience pain or clicking in your jaw. ear or facial muscles upon opening your mouth? ☐ No ☐ Yes

    Headaches? ☐ No ☐ Yes

    Please describe: ____________________

11. Do you have or have you ever had any of the following habits?

Habit		
☐ Thumb Sucking	☐ Current	☐ Previously
☐ Nail Biting	☐ Current	☐ Previously
☐ Tongue Sucking	☐ Current	☐ Previously
☐ Mouth Breathing	☐ Current	☐ Previously
☐ Tongue Thrusting	☐ Current	☐ Previously
☐ Lip Biting	☐ Current	☐ Previously
☐ Tongue Biting	☐ Current	☐ Previously
☐ Abnormal Breathing	☐ Current	☐ Previously

12. Why are you seeking an orthodontic consultation? ____________________

____

____

It is your obligation to inform us of any health changes.