

**ROGUE VALLEY ORTHODONTICS
DAVID A. WANG, DDS**

Patient Information

Male/Female

Last Name _____ First Name _____ Birthdate _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Dentist _____ Referred By _____

If Patient is a minor:
Mothers Name _____ Fathers Name _____

Primary Responsible Party Information

Last Name _____ First Name _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ SS# _____ Email _____

Employer _____

Address _____ City _____ State _____ Zip _____

Dental Insurance Co. _____ Claims Address _____

City _____ State _____ Zip _____ Phone _____ Group # _____

Secondary Responsible Party Information

Last Name _____ First Name _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ SS# _____ Email _____

Employer _____

Address _____ City _____ State _____ Zip _____

Dental Insurance Co. _____ Claims Address _____

City _____ State _____ Zip _____ Phone _____ Group # _____

Date of last physical examination _____ Physician _____

List any medications taken in the past 6 months _____

List any allergies or drug sensitivities _____

For the following questions circle Yes or No. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

- | | |
|---|---|
| Yes No Birth defects or hereditary problems? | Yes No Thumb, finger, sucking habit? Until age _____ |
| Yes No Bone fractures, any major accidents? | Yes No Abnormal swallowing habit (tongue thrusting)? |
| Yes No Rheumatoid or arthritic conditions? | Yes No Mouth breathing habit, snoring, difficulty breathing? |
| Yes No Diabetes? | Yes No Tooth grinding, jaw clenching, clicking, locking? |
| Yes No Cancer or been treated for a tumor? | Yes No Do you experience any pain or soreness in the muscles of your face, or around your ears? |
| Yes No Polio, mononucleosis, tuberculosis, pneumonia? | Yes No Have you ever been treated for "TMJ" problems? |
| Yes No Hepatitis, jaundice or liver problem? | Yes No History of extra or missing teeth? |
| Yes No AIDS or HIV positive? | Yes No Have any permanent teeth been removed? |
| Yes No Sexually transmitted disease? | Yes No Have you ever had orthodontic treatment or retainers? |
| Yes No Fainting, seizures, epilepsy or neurologic disease? | Yes No Have you ever had Periodontal (gum) treatment? |
| Yes No Mental health or behavioral problems? | Yes No Aware/concerned about under or over developed jaw? |
| Yes No Vision, hearing, tasting or speech difficulties? | Yes No Any relative with similar tooth or jaw relationships? |
| Yes No Loss of weight recently, poor appetite? | Yes No Have you had any serious trouble associated with any previous dental treatment? |
| Yes No Excessive bleeding, anemia or bleeding disorder? | Female Patient: |
| Yes No High or low blood pressure? | Yes No Are you pregnant? |
| Yes No Chest pain, shortness of breath? | Yes No Are you anticipating becoming pregnant? |
| Yes No Cardiovascular problem (heart trouble, rheumatic heart)? | What is your primary concern – Why are you here? _____ |
| Yes No Frequent headaches, colds or sore throat? | _____ |
| Yes No Any history of speech problems? | Date of most recent dental examination _____ |
| Yes No Hayfever, asthma, sinus trouble, hives? | I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. |
| Yes No Tonsil or adenoid conditions? | _____ |
| Yes No Hospitalized? For _____ | Signature of patient or parent if minor _____ Date _____ |
| Yes No Being treated by another health care professional? For _____ | |
| Yes No Chipped or otherwise injured permanent teeth? | |
| Yes No Jaw fractures, cysts, mouth infections? | |
| Yes No Periodontal "gum problems"? | |