DR. WAYNE J. CHRISTIAN
FAMILY ORTHODONTICS

"Building Generations of Smiles"

(435) 628-4422

Patient Information: ***Date*** _____

Name: Last _____ **First** _____ **Middle** _____

Birthdate _____ **Age** _____ **M / F Nickname** _____

Street Address _____ **City** _____ **St** ____ **Zip** _____

Mailing Address _____ **City** _____ **St** ____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **School** _____ **Grade** _____

Siblings (Names & Ages) _____

_____

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

Father's Name _____ **Hm Ph** _____ **Cell** _____ **Wk** _____

Mother's Name _____ **Hm Ph** _____ **Cell** _____ **Wk** _____

Email Address (if we can use this as a method of communication) _____

Primary Responsible Party Information:

Last Name _____ First _____ MI _____ Marital status _____

Street Address _____ City _____ St _____ Zip _____

Mailing Address _____ City _____ St _____ Zip _____

How long at this address _____ Own / Rent Hm Phone _____ Wk/Cell Ph _____

Soc. Sec. # _____ **Birthdate** _____ **Relationship to Patient** _____

Employer _____ Occupation _____ No. Yrs. employed _____

Previous employer (if less than 3 yrs.) _____ No. Yrs. employed _____

Best time to contact you: Morning / Afternoon / Evening. Can you be reached at work? Yes / No

Secondary Responsible Party Information:

Last Name _____ First _____ MI _____ Birthdate _____

Mailing Address _____ City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Soc. Sec. # _____ Relationship to patient _____

Employer _____ Occupation _____ No. Yrs. Employed _____

Best time to contact you: Morning / Afternoon / Evening. Can you be reached at work? Yes / No

Insurance Information:

Insurance Co. _____ Employer _____

Insurance Co. Address _____ Phone _____

Insured's Name _____ Soc. Sec. # _____ Birthdate _____

DO YOU HAVE A SECONDARY INSURANCE? Yes / No B If yes:

Insurance Co. _____ Employer _____

Insurance Co. Address _____ Phone _____

2nd Insured's Name _____ Soc. Sec. # _____ Birthdate _____

Emergency Information:

Name of nearest relative/friend not living with you _____ Relationship _____

Complete Address _____ Phone _____

PLEASE FILL OUT BOTH SIDES OF THIS FORM COMPLETELY AND BRING IT WITH YOU TO YOUR APPOINTMENT. PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST TO COPY. WE LOOK FORWARD TO SERVING YOU.

Medical History:

Name of Medical Physician_____Phone_____Last visit_____
Is the Patient currently under the care of a Physician? Yes / No
If yes, please explain_____
Women: Are you pregnant? Yes/No

Has the patient ever had any of the following diseases or medical problems?

Arthritis/Rheumatism	Yes / No	Allergic to Latex/Materials	Yes / No
Alleric to Plastic	Yes / No	Asthma/Difficulty Breather	Yes / No
Cancer	Yes / No	Convulstions/Epilepsy/Seizures	Yes / No
Diabetes	Yes / No	Handicaps/Disabilities	Yes / No
Hearing/Sight Impairment	Yes / No	Heart Murmur/Heart Defect	Yes / No
Hemophilia/Bleeding Problem	Yes / No	Hepatitis	Yes / No
HIV/Aids	Yes / No	Kidney/Liver Problems	Yes / No
Rheumatic/Scarlet Fever	Yes / No	Tuberculosis	Yes / No
Psychiatric Problems	Yes / No	Fever Blisters/Herpes	Yes / No
Fainting	Yes / No	Other Diseases	_____

Patient's current medical health is: Good / Fair / Poor
Is the patient taking any prescription / over the counter drugs? (Aspirin, Tylenol, etc.)? Yes / No
If yes, please list: _____
Please list any allergies (including drug allergies): _____
Please list any other medical problems past and present: _____
Any Hospital stays / operations? Yes / No if yes, for what and how long ago? _____

Dental History:

Name of Dentist_____Phone_____Last visit_____
Is all dental work completed? Yes / No If no, please explain_____
What results would you like to achieve with Orthodontics? _____
What bothers you the most about your teeth / bite at present? _____
Current dental health is: Good / Fair / Poor

Previous orthodontic treatment?	Yes / No	Any problems with bleeding gums?	Yes / No
Any speech problems?	Yes / No	Any missing/extra *permanent* teeth?	Yes / No
Any mouth breathing while awake?	Yes / No	Any mouth breathing while sleeping?	Yes / No
Have adenoids/tonsils been removed?	Yes / No	Any jaw joint noises or tenderness?	Yes / No

Any injuries to the: Mouth / Teeth / Chin / Head - If so, please explain _____
List any musical instrument played: _____

Habits:

Clenching	Yes / No	Grinding	Yes / No	Nail biting	Yes / No
Lip Sucking/Biting	Yes / No	Tongue Thrust	Yes / No	Thumb/Finger sucking	Yes / No

We want to get better acquainted. Please take a minute to tell us about the patient. (hobbies, achievements, favorites, likes and dislikes.) Anything to help us get to know YOU!_____

_____

_____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

I understand the information given is correct to the best of my knowledge. I also understand that information given will be held in strict confidence and that it is my responsibility to inform this office of any changes in the patient's medical/dental status. I understand that where appropriate, credit bureau reports may be obtained. I authorize Dr. Christian and staff to perform any necessary dental services that may be needed during diagnosis and treatment.

Parent /Patient signature Date