WRIGHT ORTHODONTICS

www.wrightortho.com

MY SMILE ROCKS!

4055 W Chandler Blvd, Ste 1
Chandler, AZ 85226
Phone: 480-753-6300

453 W 5th Street
Mesa, AZ 85201
Phone: 480-835-0567

1118 N. Val Vista Rd.
Mesa, AZ 85213
Phone: 480-969-1514

1. PATIENT INFORMATION

Name _____ _____ Sex ___ Birthday _____ Age ___
First MI Last Nickname

Cell Phone _____ Alt Phone _____

Address _____ City _____ State _____ Zip _____

School _____

2. RESPONSIBLE PARTY INFORMATION

FATHER or SELF or GUARDIAN INFORMATION

Name _____

Address _____

City _____ State ___ Zip _____

Cell Phone _____ Alt Phone _____

Email Address _____

Birthday _____ Age _____ Sex ____ Marital Status ___

SS# _____

How long at this Address? ___

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State ___ Zip _____

Work Phone _____

# of Years Employed _____ Occupation _____

Orthodontic Coverage? _____ Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State ___ Zip _____

Insurance Phone _____ Ext. _____

Id # _____

MOTHER or SPOUSE INFORMATION

Name _____

Address _____

City _____ State ___ Zip _____

Cell Phone _____ Alt Phone _____

Email Address _____

Birthday _____ Age _____ Sex ____ Marital Status ___

SS# _____

How long at this Address? ___

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State ___ Zip _____

Work Phone _____

# of Years Employed _____ Occupation _____

Orthodontic Coverage? _____ Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State ___ Zip _____

Insurance Phone _____ Ext. _____

Id # _____

3. DENTIST INFORMATION

Dentist's name			
Address	City	State	ZIP Code
Phone ( )		Fax ( )	

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PATIENT HISTORY FORM,continued

DENTAL/MEDICAL HISTORY

What would you like to change about your smile?			
Do you have any pain now? ❑ Yes ❑ No		Do your gums bleed? ❑ Yes ❑ No	
Have you ever had any serious/difficult problem associated with previous dental work? ❑ Yes ❑ No		Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ❑ Yes ❑ No	
Physician name	Physician phone ( )	Date of last visit	
Are you currently under a doctor's care? If yes, why? ❑ Yes ❑ No		Are you taking any prescription drugs? ❑ Yes ❑ No	
Are you pregnant? ❑ Yes ❑ No			

Have you ever had any of the following diseases or medical problems?

Prosthesis	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Congenital Heart Defect	❑ Yes ❑ No	Sev./freq. headaches	❑ Yes ❑ No
Heart attack	❑ Yes ❑ No	Shingles	❑ Yes ❑ No	Convulsions/ Epilepsy	❑ Yes ❑ No	High/low blood pressure	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Fever blisters	❑ Yes ❑ No	Abnormal bleeding	❑ Yes ❑ No	Drug/alcohol abuse	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Venereal disease	❑ Yes ❑ No	Artificial valves	❑ Yes ❑ No	Blood transfusion	❑ Yes ❑ No
Rheumatic fever	❑ Yes ❑ No	Ulcers/colitis	❑ Yes ❑ No	Heart surgery/ Pacemaker	❑ Yes ❑ No	Anemia/ radiation treatment	❑ Yes ❑ No
HIV+/AIDS	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Hospital stays other than for pregnancy	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No
Hemophilia	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Kidney/liver problems	❑ Yes ❑ No	Breathing difficulty	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No	Mitral valve prolapse	❑ Yes ❑ No	Other Explain:	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No	Scarlet fever	❑ Yes ❑ No	Artificial bones/ joints	❑ Yes ❑ No		

ALLERGIES

Aspirin	❑ Yes ❑ No	Pain pills (Codeine)	❑ Yes ❑ No	Latex	❑ Yes ❑ No	Penicillin	❑ Yes ❑ No
Antibiotics	❑ Yes ❑ No	Dental Anesthetics	❑ Yes ❑ No	Tetracycline	❑ Yes ❑ No	Other	❑ Yes ❑ No
Details							

NOTICE OF PRIVACY PRACTICES

We are dedicated to protecting your personal medical information and following all provisions required by law. You are entitled to review our complete Privacy Notice which describes how we may use and disclose your medical records while you are receiving care at Imagine Orthodontics. ***A laminated copy of our Notice of Privacy Practices is maintained at the reception desk and is available to you for review or to obtain a photo copy.***

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address) _____

Relationship to patient _____ Phone # ( ) _____

REFERRALS

Whom may we thank for referring you? ❑ Dentist ❑ Staff ❑ Internet ❑ Special Offer ❑ Friend ❑ Other _____

Name _____ Phone # ( ) _____

I understand the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Doctor's Signature Date

I give Wright Orthodontics permission to perform an examination and to take any diagnostic records they deem necessary for an evaluation and treatment.

I have received a copy of the **Health Insurance Portability and Accountability Act** from this provider.

_____	_____
Patient Name	Date
_____	_____
Parent/Legal Guardian Signature	Relationship to Patient

Let's Get Acquainted!

Name:_____

We want to get to know you! Please answer the following questions to help us better our relationship with you, our Rockstar Patient!

The name or nickname I like to be called is_____

In my free time, I like to _____

The hobbies/sports I enjoy are _____

My favorite musician is _____

Tell us about your pets _____

I think having braces would be _____

Everyone has something special about him/her. Tell us what is special about you!

_____

Do you have any family and friends that come to our office? _____

What are their names:_____

Is there anything else that you would like us to know? _____

_____

Thank you for this opportunity to get to know you better!