Wendy Struss Willett, D.D.S., M.S.

Orthodontist

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WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ______________________________

Name: ______________________________
LAST FIRST MI

I Prefer to be called: ____________________ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age: _____ SS#: ______________

Home Address: ______________________________
APT/CONDO#

____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home: #: ________________ Pager/Other #: ______________

Work #: ________________ Ext: __________

Email:______________________________

Employer: ______________________________

Employer's Address: ______________________________

How long there? ________ Occupation: ______________________

Where & when are the best times to reach you? ________________

Who may we **Thank** for referring you? ____________________

Other family members seen by us: ______________________

______________________ Relationship: ______________

Previous / Present Dentist: ______________________
(Please Circle)

Last Visit Date: ______________________________

2 Spouse Information

Their Name: ______________________________

Employer: ______________________________

Work #: ____________ Ext: __________ SS #: ______________

Birthdate: ____________________ DL #: ________________

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: ______________________________

Relation: ______________________________

Work #: ________________ Home #: ________________

3 Person Responsible for Account

Name: ______________________ Relation: ______________

Billing Address: ______________________________

____
CITY STATE ZIP

Work #:______________Ext:_____Home #:______________

Employer: ______________________________

SS#: ____________________ Date of Birth: ________________

I also authorize your office, when appropriate, to obtain credit bureau reports concerning my credit history.

____

Signature of Responsible Party Date

4 Primary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthday: _____/_____/_____ & SS #: ______________

Insured's Employer: ______________________________

Orthodontic Coverage? ❑ Yes ❑ No Max Amt. ______________

Secondary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthday: _____/_____/_____ & SS #: ______________

Insured's Employer: ______________________________

Orthodontic Coverage? ❑ Yes ❑ No

5 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ____

Phone #: _________________________ Date of Last Visit: _____________

Your Current Physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician?

❑ Yes ❑ No

Please explain: ____

Are you taking any prescription/over-the-counter drugs?

❑ Yes ❑ No

Please list each one: ____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # _______________

Are you nursing? ❑ Yes ❑ No

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

Y	N	Heart Attack/Stroke	Y	N	Psychiatric Problems
Y	N	Cancer/Chemotherapy	Y	N	Epilepsy/Seizures/Fainting Spells
Y	N	Heart Murmur	Y	N	Diabetes/Tuberculosis (TB)
Y	N	Rheumatic Fever	Y	N	Drug/Alcohol Abuse
Y	N	HIV +/AIDS	Y	N	Venereal Disease
Y	N	Heart Surgery/Pacemaker	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Shingles	Y	N	Ulcers/Colitis
Y	N	Mitral Valve Prolapse	Y	N	Congenital Heart Defect
Y	N	Kidney Problems	Y	N	Anemia/Radiation Treatment
Y	N	Artificial Bone/Joints	Y	N	Asthma/Arthritis
Y	N	Artificial Valves	Y	N	Difficulty Breathing
Y	N	Sinus Problems	Y	N	Hospitalized for Any Reason
Y	N	High/Low Blood Pressure	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Blood Transfusion
Y	N	Severe/Frequent Headaches	Y	N	Emphysema/Glaucoma

Please list any serious medical condition(s) that you have ever had: _____

____

____

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Other
Y	N	Erythromycin	Y	N	Codeine			

Please list any other drugs that you are allergic to: ___________________

____

____

6 Dental History

Why have you come to the orthodontist today?

____

____

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? ____________________________

-- a day do you brush? ______________________________________

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status.

I certify that I am covered by insurance with

____,
(Name of insurance company(ies)

and assign directly to Dr. Wendy Struss Willett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether of not paid by insurance. I authorize the use or this signature on all my insurance submissions, whether manual or electronic

____

SIGNATURE DATE

Office Use Only Office Use Only **Office Use Only**

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials: __________ Date: __________

Doctor's Comments: ____

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