

Vancouver Orthodontic Specialists, PLLC

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Durk Irwin, D.M.D.

PATIENT INFORMATION

Today's Date: _____ Nickname: _____

Name: _____

Home Phone: _____

Home Address: _____

Email Address: _____

Social Sec. Number: _____

Birthdate: _____ Age: _____ Male _____ Female _____

Hobbies/Sports: _____

General Dentist: _____

Last Visit Date: _____

School (if applicable) _____ Grade: _____

Employer (if applicable) _____

Work Phone: _____

Whom may we thank for referring you? _____

PATIENT INFORMATION IF APPLICABLE

WHO IS ACCOMPANYING THE PATIENT?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

List brothers/sisters with age: _____

Parents' Marital Status: Single Married Partnered
 Separated Divorced Widowed

MOTHER'S INFORMATION

Mother Step Mother Guardian

Name: _____ Birthdate: _____

Work Phone: _____ Ext: _____

Home Phone: _____

Employer: _____

How long at Current Job: _____

Job Title: _____

Social Sec. Number: _____

FATHER'S INFORMATION

Father Step Father Guardian

Name: _____ Birthdate: _____

Work Phone: _____ Ext: _____

Home Phone: _____

Employer: _____

How long at Current Job: _____

Job Title: _____

Social Sec. Number: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name: _____

Work Phone: _____ Ext: _____

Home Phone: _____

SPOUSE INFORMATION IF APPLICABLE

Spouse Name: _____

Social Sec. Number: _____

Employer: _____

Work Phone: _____ Ext: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

Home Phone: _____

Employer: _____

Work Phone: _____ Ext: _____

INSURANCE INFORMATION

PRIMARY ORTHODONTIC INSURANCE

Insurance Co. Name: _____

Insurance Co. Phone: _____

Group Number (Plan, Local or Policy) _____

Policy Owner's Name: _____

Relation to Patient: _____

Policy Owner's Birthdate: _____

Social Sec. Number: _____

Policy Owner's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Insurance Co. Name: _____

Insurance Co. Phone: _____

Group Number (Plan, Local or Policy) _____

Policy Owner's Name: _____

Relation to Patient: _____

Policy Owner's Birthdate: _____

Social Sec. Number: _____

Policy Owner's Employer: _____

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The custodial parent is financially responsible for the services and should seek any reimbursement from the other parent.

PATIENT HEALTH INFORMATION

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

Have you ever been evaluated or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Have you ever had any pain/tenderness in your jaw joint? (TMJ/TMD) Yes No

Do you brush your teeth daily? Yes No

Do you floss your teeth daily? Yes No

Do you bleach your teeth? Yes No

Are you currently under the care of a physician? Yes No

Physician: _____

Phone Number: _____ Date of last visit: _____

Please describe you/your child's current physical health: Good Fair Poor

Please list all medications currently being taken: _____

Please list any food/drug allergies: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|--------------------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Clenching/ Grinding Teeth |
| Y N Anemia | Y N Congenital Heart Defect |
| Y N Artificial Bones/ Joints/ Valves | Y N Convulsions/ Epilepsy |
| Y N Asthma/ Arthritis | Y N Diabetes |
| Y N Blood Transfusion | Y N Difficulty Breathing |
| Y N Cancer/ Chemotherapy | Y N Drug/ Alcohol Abuse |
| Y N Emphysema | Y N Mitral Valve Prolapse |
| Y N Epilepsy/ Seizures/ Fainting | Y N Mouth Breather |
| Y N Fever Blisters/ Herpes | Y N Nail Biting |

- | | |
|---------------------------------|--------------------------------|
| Y N Glaucoma | Y N Psychiatric Problems |
| Y N Handicaps/ Disabilities | Y N Radiation Treatment |
| Y N Hearing Impairment | Y N Rheumatic/ Scarlet Fever |
| Y N Heart Attack/ Stroke | Y N Severe/ Frequent Headaches |
| Y N Heart Murmur | Y N Shingles |
| Y N Heart Surgery/ Pacemaker | Y N Sinus Problems |
| Y N Hemophilia | Y N Speech Problems |
| Y N Hepatitis | Y N Thumb/ Finger Sucking |
| Y N High/ Low Blood Pressure | Y N Tongue Thrust |
| Y N HIV/ AIDS | Y N Tuberculosis (TB) |
| Y N Hospitalized for any reason | Y N Ulcers/ Colitis |
| Y N Kidney/ Liver Problems | Y N Venereal Disease |
| Y N Lip Sucking/ Biting | |

PLEASE LIST ANY OTHER MEDICAL PROBLEMS THAT YOU HAVE HAD: _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____

Phone Number: _____

Address: _____

I understand that the information that I have given is correct to the best of my knowledge. I authorize the sharing of this information with my medical and/or dental provider(s).

I authorize the dental staff to perform the necessary dental services needed.

I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics.

Signature of Patient/ Signature of Parent or Guardian _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient or guardian and patient named healthy.
 Doctor's Comments: _____ Initials: _____ Date: _____
