Vancouver Orthodontic Specialists, PLLC
406C SE 131st Ave, Ste 306
Vancouver, WA. 98683
Phone: 360-883-6713 Email: vancortho@hotmail.com
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 childs current physical heath: ☐ Good ☐ Fair ☐ Poor

Please list all medications currently being taken: __________

____

____

Please list any food/drug allergies: ________________

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____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Bones/ Joints/ Valves
Y N Asthma/ Arthritis
Y N Blood Transfusion
Y N Cancer/ Chemotherapy
Y N Emphysema
Y N Epilepsy/ Seizures/ Fainting
Y N Fever Blisters/ Herpes
Y N Clenching/ Grinding Teeth
Y N Congential Heart Defect
Y N Convulsions/ Epilepsy
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/ Alcohol Abuse
Y N Mitral Valve Prolapse
Y N Mouth Breather
Y N Nail Biting
Y N Glaucoma
Y N Handicaps/ Disabilities
Y N Hearing Impairment
Y N Heart Attack/ Stroke
Y N Heart Murmur
Y N Heart Surgery/ Pacemaker
Y N Hemophilia
Y N Hepatitus
Y N High/ Low Blood Pressure
Y N HIV/ AIDS
Y N Hospitalized for any reason
Y N Kidney/ Liver Problems
Y N Lip Sucking/ Biting
Y N Psyciatric Problems
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Severe/ Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Speech Problems
Y N Thumb/ Finger Sucking
Y N Tongue Thrust
Y N Tuberculosis (TB)
Y N Ulcers/ Colitis
Y N Venereal Disease

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

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____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: ___________________________

Phone Number: ____________________

Address: _________________________

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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.

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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: __________

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