

# WELCOME TO DR. WELMERINK'S OFFICE

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Our goal is to make everyone's visit pleasant and educational.

Today's Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last First MI MR MRS MS DR

I prefer to be called: \_\_\_\_\_  Male  Female Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Home Address: \_\_\_\_\_  
City State Zip

Hm # \_\_\_\_\_ Wk # \_\_\_\_\_ Ext: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Whom may we Thank for referring you? Please check all that apply.  Dentist / Hygienist  Mail flyer  Yellow pages  
 Internet (search engine)  Our Website  Saw sign  Magazine ad  Other \_\_\_\_\_  
 Patient (please specify all if more than one) \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Last visit date: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk # \_\_\_\_\_ Ext. \_\_\_\_\_

Employer's Address \_\_\_\_\_

Occupation: \_\_\_\_\_ How long at current job: \_\_\_\_\_

Where & when are the best times to reach you? \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ Cell# \_\_\_\_\_

Employer: \_\_\_\_\_ Wk # \_\_\_\_\_ Ext. \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Hm # \_\_\_\_\_ Wk# \_\_\_\_\_ Ext. \_\_\_\_\_ Cell# \_\_\_\_\_ Relationship \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_ Relationship \_\_\_\_\_

Billing Address: \_\_\_\_\_  
City State Zip

Employer: \_\_\_\_\_ Wk # \_\_\_\_\_ Ext. \_\_\_\_\_ Hm# \_\_\_\_\_

## Primary Orthodontic Insurance:

Orthodontic Coverage?  Yes  No Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_ Group # (Plan, Local, Policy #) \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
Relationship \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

(Continued on back)

**Secondary Orthodontic Insurance:**

Orthodontic Coverage? Yes No Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_ Group # (Plan, Local, Policy #) \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Relationship

Policy Owner's Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

**What are the main concerns that you would like orthodontics to accomplish?** \_\_\_\_\_

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

If yes, where: \_\_\_\_\_

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

Have there been any injuries to your: Face Mouth Teeth Chin

Do your gums ever bleed? 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

Your current dental health is: Good Fair Poor Do you like your smile? Yes No

**Have you ever had any of the following medical problems?**

Y N Abnormal Bleeding/Hemophilia

Y N Diabetes

Y N HIV+ / AIDS

Y N Anemia / Radiation Treatment

Y N Difficulty Breathing

Y N Kidney / Liver problems

Y N Allergic to Latex / Metals

Y N Emphysema / Glaucoma

Y N Mitral Valve Prolapse

Y N Any Hospital Stays/Operations

Y N Handicaps / Disabilities

Y N Mouth Breather

Y N Asthma

Y N Heart Attack / Stroke

Y N Rheumatic / Scarlet Fever

Y N Arthritis

Y N Heart Murmur

Y N Severe / Frequent Headaches

Y N Cancer / Chemotherapy

Y N Heart Surgery / Pacemaker

Y N Sinus Problems

Y N Clenching / Grinding Teeth

Y N Hepatitis

Y N Speech Problems

Y N Congenital Heart Defect

Y N Herpes / Fever Blisters

Y N Tongue Thrust

Y N Convulsions / Epilepsy

Y N High / Low Blood Pressure

Y N Tuberculosis (TB)

Please discuss any medical problems that you have had: \_\_\_\_\_

Please list all drugs you are allergic to: \_\_\_\_\_

**Personal Physician:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_ Are you currently under the care of a physician? Yes No

Your current physical health is: Good Fair Poor

Please list all drugs you are currently taking: \_\_\_\_\_

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

Are you pregnant? Yes No Week #: \_\_\_\_\_

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

Signature

Date

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