

W DAVID L. WAY, D.D.S., M.S. *Specialist in Orthodontics*

1.
PATIENT'S INFORMATION

Today's date: _____ M _____ F _____

Name: _____
last first m

Nickname: _____ SS# _____

Birth Date: _____ Age: _____

Hm #: (_____) _____ Wk #: (_____) _____

E-mail: _____

Home Address: _____

_____ city state zip

General Dentist: _____

Last visit date: _____

Marital status: Single Married
Separated Widowed Divorced

2.
EMPLOYER

Employer: _____

Employer Address: _____

Wk #: (_____) _____

SS #: _____

3.
RESPONSIBLE PARTY

Name: _____

Relation: _____

Billing Address: _____

_____ city state zip

Previous Address: _____

_____ city state zip

Hm#: (_____) _____ Wk #: (_____) _____

E-mail: _____

Employer: _____

SS #: _____

4.

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes _____ No _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: _____

SS # _____

Policy Owner's Employer: _____

5.

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes _____ No _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: _____

SS #: _____

Policy Owner's Employer: _____

6.

MEDICAL HISTORY

- | | | |
|---|---|---------------------------------|
| Y | N | Abnormal bleeding |
| Y | N | Allergies to any Drugs |
| Y | N | Allergies to Latex or Metals |
| Y | N | Allergies to Plastics |
| Y | N | Any Hospital Stays |
| Y | N | Any Operations |
| Y | N | Asthma |
| Y | N | Cancer |
| Y | N | Congenital Heart Defects |
| Y | N | Convulsions / Epilepsy |
| Y | N | Diabetes |
| Y | N | Handicaps / Disabilities |
| Y | N | Hearing Impairment |
| Y | N | Heart Murmur |
| Y | N | Hemophilia |
| Y | N | Hepatitis |
| Y | N | HIV + / AIDS |
| Y | N | Kidney / Liver Problems |
| Y | N | Rheumatic Fever / Scarlet Fever |
| Y | N | Seasonal Allergies |
| Y | N | Tuberculosis |

Please discuss any medical problems you have had:

