T. Yogi Building • 45-1048 Kamehameha Highway, Suite B • Kaneohe, Hawaii 96744
Ala Moana Building • 1441 Kapiolani Boulevard, Suite 1103 • Honolulu, Hawaii 96814
235-6801 • All Calls are forwarded
Visit us at • computer: www.drwall.net • mobile: www.drwall.info

Welcome to Our Office!

In order to help us provide you with the best possible care, please fill in the front and back of this Patient Information Form to the best of your knowledge and bring it to your appointment. Please feel free to ask questions. Thank you!

YOUR CONCERN IS OUR CONCERN.

Patient's Name _____ _____ _____
First Nickname M.I. Last Age Birthdate

Home Address _____ ☐Male ☐Female
Street City Zip Code

Home Phone _____ Cell Phone _____ Business Phone _____

Employer _____ Occupation _____ _____
(For Office Use Only)

Spouse's Name _____

Employer _____ Occupation _____

Business Phone _____ Cell Phone _____ _____
(For Office Use Only)

What motivated you to seek orthodontic treatment? Check all that apply:

☐ General dissatisfaction with the facial appearance

☐ Crowded / Crooked Teeth ☐ Open Bite ☐ Crossbites ☐ Jaw Pain
☐ Spaced / Missing Teeth ☐ Underbite ☐ Jaw Joint Problem ☐ Ugly Smile
☐ Protruding Teeth / Lips ☐ Deep Overbite ☐ Small / Large Jaws ☐ Facial Growth Disharmony

Has anyone in the family had orthodontic treatment? _____ If so, by whom? _____

Please let us know who referred you to our office so we may thank them! _____

Patient's Dentist _____ Address or Location _____

Do you have insurance coverage for orthodontic treatment? ☐Yes ☐No

If so, please check provider:

☐ Hawaii Dental Service | ☐ HMSA | ☐ Met Life | ☐ Other: _____

Membership No. _____ Group No. _____ Subscriber _____

Yes / No Coverage _____ Maximum _____ Age Limit _____

MEDICAL HEALTH HISTORY

MEDICAL HEALTH HISTORY: Have you ever had any of the following medical problems? This information is necessary to help us complete our diagnosis and to provide you with the best possible care. General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including biphosphonates) can effect your orthodontic treatment. Medications to treat osteoporosis may inhibit tooth movement, decrease bone healing, and increase bone problems in the jaws.

Yes	No		Yes	No	
☐	☐	High Blood Pressure / Hypertension	☐	☐	Heart Murmur / Problem
☐	☐	Thyroid / Parathyroid Problem	☐	☐	Congenital Heart Defect
☐	☐	Hyperactivity / Hypoactivity	☐	☐	Rheumatic Fever / Heart
☐	☐	Emotional Problems	☐	☐	Diabetes
☐	☐	Fainting / Dizziness	☐	☐	Spina Bifida
☐	☐	Nervous Disorders	☐	☐	Cancer Treatments
☐	☐	Cerebral Palsy	☐	☐	Prolonged Bleeding
☐	☐	Herpes Virus of Lips / Mouth	☐	☐	Anemia
☐	☐	Kidney / Liver Problems	☐	☐	Epilepsy
☐	☐	Jaundice	☐	☐	Asthma
☐	☐	Hepatitis	☐	☐	Hormone Treatments
☐	☐	Tuberculosis	☐	☐	Bone Problem: Osteoporosis
☐	☐	Glaucoma	☐	☐	Bisphosphonate medication (Actonel, Boniva, Didronel, Fosamax, Reclast)
☐	☐	Latex / Metal Allergy			
☐	☐	Other Known Allergies: _____			

☐ ☐ WOMEN: Have you ever been hospitalized for anything other than the birth of a baby?

☐ ☐ Are you currently under the care of a physician for something other than the common cold?

☐ ☐ Is there any other illness, pregnancy, or treatment that you are receiving that is not listed above? Please describe them and/or list any medications now being taken, and why:

_____

DENTAL HEALTH HISTORY

Yes	No	
☐	☐	Have recent PANORAMIC or FULL MOUTH X-RAYS been taken at the dentist's office? When? _____
☐	☐	Do you have difficulty breathing through the nose and breathe mainly through the mouth?
☐	☐	Do you have any speech problems?
☐	☐	Do you grind your teeth? ☐ while sleeping ☐ while awake
☐	☐	Do you clench your teeth a lot?
☐	☐	Do you have any difficulty chewing or swallowing food?
☐	☐	Do you experience pain in the jaws or jaw joints when opening or closing the mouth or while chewing?
☐	☐	Do your jaw muscles ache: ☐ in the morning ☐ at night
☐	☐	Have you sustained any severe head or facial injuries, or any trauma to the jaws?
☐	☐	Do you have any chipped teeth as a result of an accident?
☐	☐	Have you been informed of missing permanent teeth? Where? _____
☐	☐	Do you have any implants? Where? _____
☐	☐	Have you had any previous orthodontic consultation or treatment? By whom? _____

CONSENT

This information is confidential and is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in medical status. I authorize Dr. Michael J. Wall and his staff to perform necessary dental services with my informed consent, that are needed during diagnosis and treatment.

_____

Patient Signature Date