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 ____________ Primary Cell Phone * ____________ School & Grade ____________

Person Responsible for this account: ☐Both Parents ☐Mother ☐Father ☐Other ____________

Mother's Name ______________________________ ____________
(For Office Use Only)
Address if different from child's ______________________ Occupation ____________
Employer ____________ Bus. Phone ____________ Cell Phone ____________

Father's Name ______________________________ ____________
(For Office Use Only)
Address if different from child's ______________________ Occupation ____________
Employer ____________ Bus. Phone ____________ Cell Phone ____________

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 ____________

Does the patient have insurance coverage for <u>orthodontic</u> 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: ______________________________

☐ ☐ Has your child ever been hospitalized for anything (other than birth)?

☐ ☐ 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? __________
☐	☐	Does your child have difficulty breathing through the nose and breathe mainly through the mouth?
☐	☐	Does your child have any speech problems?
☐	☐	Do you notice your child clenching or grinding teeth? If so, is it ☐ while sleeping ☐ while awake
☐	☐	Did your child ever suck a thumb or fingers? If so, until what age? __________
☐	☐	Is there any difficulty chewing or swallowing food?
☐	☐	Does your child complain about pain in the jaw or jaw joints when opening or closing the mouth while chewing?
☐	☐	Has there been any severe head or facial injuries, or any trauma to the jaws?
☐	☐	Does your child have any chipped teeth as a result of an accident?
☐	☐	Has your child been informed of missing permanent teeth? Where? __________
☐	☐	Has your child 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 (Parent/Guardian if under 18) Date