WARDELL ORTHODONTICS

Bruce S. Wardell, DMD

We are pleased to welcome you to our practice. Please take a few minutes to fill out this welcome form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you to maintain your dental health and give you the beautiful smile that you deserve.

Patient Information

Today's Date ________________

Patient's name ______________________________________ **SSN** ________________
Last First Middle Initial

Address ____
Street City State Zip Code

Sex ☐ M ☐ F Age _____ Birthdate ____________ Home phone ____________________

Mother's name ____________________________ Cell phone ____________________

Employer ____________________________ Work phone ____________________

Email Address ____________________________

Father's name ____________________________ Cell phone ____________________

Employer ____________________________ Work phone ____________________

Email Address ____________________________

Who may we thank for referring you today? ______________________________

Responsible Party

Person Responsible for Account ______________________________________
Last First Middle Initial

Relation to patient __________________ **Birthdate** ____________ **SSN** ______________

Home Address ____________________________ Driver's license # __________________

City, State, Zip ____________________________ Cell phone __________________

Is patient covered by insurance? ☐ Yes ☐ No **Policy holder's Name** __________________

Insurance Company (If applicable) ______________________________________

Policy / Contract # __________________ Group # ______________ Subscriber # ______________

Secondary Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Policy holder's Name __________________ Relation to patient __________ Birthdate __________

Address (If different from above) ____________________________ Home Phone ______________

____ Work Phone ______________

Policy holder Employed by ____________________________ Cell Phone ______________

Insurance Company ____________________________ SSN ______________

Policy / Contract # __________________ Group # ______________ Subscriber # ______________

Dental History

Dr. Wardell Reviewed ____________________________Date____________

Reason for today's visit ___________________________________ **Date of last dental exam** ______________

Dentist's Name ________________________________**Dentist's email**_________________________________

Address of Dentist ____

Check the box if the patient has had problems with any of the following:

- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Grinding of teeth
- ☐ Bad breath
- ☐ Sensitive teeth to cold or biting
- ☐ Food collection between teeth
- ☐ History of gum disease
- ☐ Broken fillings/cracked teeth
- ☐ Sores or abcess in your mouth

Medical History

Dr. Wardell Reviewed ___________________________ Date___________

Physician's name ____________________________________ **Date of last visit** __________________________

Have you had any serious illnesses or operations? **Yes** **No** If yes, describe ___________________________

Do you have any bleeding disorders? …………… . **Yes** **No** If yes, describe___________________________

Do you have an allergy to latex rubber?....…. ……. **Yes** **No** If yes, describe___________________________

Do you have an allergy to any metals? …………….**Yes** **No** If yes, describe ___________________________

Do you have an allergy to any medications? ………**Yes** **No** If yes, describe __________________________

Do you take antibiotics prior to dental treatment? **Yes** **No**

(Females only) Is the patient pregnant or does the patient think that she may be pregnant? **Yes** **No**

Circle any condition that you have been diagnosed with or required past treatment by your doctor:

ADD/ADHD	Blood diseases	Heart problems	Kidney Disease
Anemia	Cancer	Hemophilia	Liver Problems
Arthritis	Circulatory problems	Hepatitis	Radiation Treatment
Artificial heart valve	Diabetes	High blood pressure	Respiratory Disease
Asthma	Epilepsy	HIV/AIDS	Stroke
Autism spectrum disorder	Heart murmur	Jaw Pain	Tuberculosis

List any medications patient is currently taking ____

Authorization

I certify that I, and/or my dependent(s), have the insurance coverage with ________________________________

(Name of Insurance Company(ies)

and assign directly to Dr. Bruce Wardell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payable by insurance. I authorize the use of my signature and social security number on all insurance submissions. The above named doctor may use my health care information and may disclose my information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. If patient and/or responsible party DO NOT have insurance coverage the signature on the second line below certifies that all information provided is accurate and authorizes Dr. Bruce Wardell to provide orthodontic treatment.

____ _____________________

Signature of Patient, Parent, or Guardian WITH INSURANCE COVERAGE Print Name Date

____ _____________________

Signature of Patient, Parent, or Guardian WITHOUT INSURANCE COVERAGE Print Name Date