Warford Orthodontics

Changing the World, One Smile at a Time.

Specialists in Adult and Child Orthodontics and Dentofacial Orthopedics

John H. Warford, Jr., DDS
John H. Warford, Sr., DDS
www.warfordorthodontics.com

Patient # _____ Date: _____

About You

Patient Name: _____
LAST FIRST M.I.

Birthday: _____ Age: _____ Marital Staus: ___

SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

How long at current address? _____

Dentist Name: _____

Physician Name: _____

Employer: _____

Position: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact you by e-mail? Yes _____ No _____

E-mail address: _____

How long at current job? _____

If less than 6 months, please list previous employer:

_____

Spouse Information

Spouse's Name: _____
LAST FIRST M.I.

Birthday: _____ Age: _____ Marital Status: ___

SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

How long at current address? _____

Dentist Name: _____

Physician Name: _____

Employer: _____

Position: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact you by e-mail? Yes _____ No _____

E-mail address: _____

How long at current job? _____

If less than 6 months, please list previous employer:

_____

Children

Name	Age	Birthdate

Continued on back side

Insurance Information

Primary Dental Insurance

Orthodontic Coverage? Yes _____ No _____
Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Group #: _____
Relationship to Patient: _____

Secondary Dental Insurance

Orthodontic Coverage? Yes _____ No _____
Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Group #: _____
Relationship to Patient: _____

Medical Information

Y N Are you in good health?
Y N Heart Problems?
- **Y N** Rheumatic Fever
- **Y N** Heart Murmur
- **Y N** Shortness of Breath

Y N Liver Problem?
- **Y N** Do you have hepatitis?

Y N Nerve/Neurological problems?
Y N History of Fainting or Dizziness?
Y N Lung/Breathing Problems?
- **Y N** Asthma

Y N Blood/Bleeding Problems?
Y N History of Tobacco Use?
If so, what kind? _____
Y N Problems with Healing?
Y N Psychological/Emotional Problems?
Y N High/Low Blood Pressure?
Y N Cancer or History of Cancer?
Y N HIV/Aids?
Y N Rheumatism or Arthritis?
Y N History of Drug Use?
Y N Tuberculosis?
Y N Hormone/Endocrine Problems?
Y N Do you get frequent cold sores?
Y N Do you have have artificial joint/ implants?
Y N Thyroid Problems?
Y N Kidney Problems?
Last physical examination was on: _____

Please list all medications: _____
_____
Y N Are you currently under medical care?
Y N Are you aware of any disease, condition or problem not listed that we should know about?
If yes, what? _____
Y N Are you allergic to any medications?
Please list: _____
Y N Do you have asthma or seasonal/ environmental allergies?

Dental Information

Y N Have you seen a general dentist in the last year?
Y N Any pain, clicking or discomfort in or near the ear (TMJ)?
Y N Has your mouth, face, or teeth been injured by a fall/accident?
Y N Have you been informed of missing or extra permanent teeth?
Y N Are you aware of any "gum" or periodontal problems?
Y N Has a physician or dentist advised antibiotics before a dental exam?

Do you have or ever had any of the following habits?
- **Y N** Cheek, tongue or lip biting
- **Y N** Thumb or finger sucking
- **Y N** Mouth breathing
- **Y N** Speech problems
- **Y N** Clenching teeth
- **Y N** Tongue thrusting
- **Y N** Grind teeth

Y N Have you ever worn a helmet for head molding?
Y N Have you been examined by an orthodontist before?
If yes, by whom?
Y N Have you had a recommendation that you need orthodontic treatment?
Y N Have other members of your family had orthodontic treatment?
If yes, who were they?

The greatest compliment we can receive is the referral of friends and family. Whom may we thank for referring you? _____
_____
Address (if known) _____

Please share your orthodontic concerns: _____
_____
_____

Please share the desired outcome of orthodontic transformation: _____
_____
_____

Please share any special concerns that we can help with: _____
_____
_____

_____ _____
Signature **Date**