John H. Warford, Jr., DDS

1145 West Turnpike Avenue
Bismarck, North Dakota 58501
ph: 701.255.1311
fax: 701.224.1102
toll free: 800.732.3768
www.warfordorthodontics.com

Warford Orthodontics

Changing the World, One Smile at a Time.

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The Region's Only Top 1% Invisalign® Provider

Date: _____

About You

Patient 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: _____

How long at current employer? _____

If less than 6 months list previous employer: _____

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

E-mail address: _____

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

Address (if known) _____

Significant Other/Spouse

Significant Other: _____
LAST FIRST M.I.

Birthday: _____ Marital Status: _____

SS#: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Position: _____

How long at current employer? _____

If less than 6 months list previous employer: _____

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

E-mail address: _____

Children

Name	Age	Birth date

Patient Emergency Contact

In case of emergency, please contact:

Name of nearest relative or family friend not living with you

PERMANENT FAMILY CONTACT

Name: _____

CONTACT ADDRESS AND PHONE NUMBER

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship to Patient: _____

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Insurance Information

Primary Dental Insurance

Insurance Co Name: _____

Address: _____

City: _____ State _____ Zip: _____

Insurance Co Phone: _____

Insured's Name: _____ Insured's DOB: _____

Insured ID # _____ Insured Group # _____

Insured SS # _____ Relationship to Patient _____

Insured Employer: _____ Employer Phone # _____

*** Please bring in a copy of your insurance card to be scanned**

Secondary Dental Insurance

Insurance Co Name: _____

Address: _____

City: _____ State _____ Zip: _____

Insurance Co Phone: _____

Insured's Name: _____ Insured's DOB: _____

Insured ID # _____ Insured Group # _____

Insured SS # _____ Relationship to Patient _____

Insured Employer: _____ Employer Phone # _____

*** Please bring in a copy of your insurance card to be scanned**

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 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 or 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? _____

_____ _____

Signature **Date**

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes to this information promptly. I authorize release of any information to insurance carriers and to other health care providers involved in coordination of care. I authorize Dr. John Warford and the staff of Warford Orthodontics to perform any necessary dental services that are needed during diagnosis and treatment. I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____

For Office Use Only: Updates: (Date and Initial) _____ _____ _____