LAWRENCE E. WRIGHT, D.D.S., M.S., PLLC

767 National Road, Wheeling, WV 26003

Patient Information

Date____________ Date of Birth____________________

Patient's Name ______________________________ (Last, First, Middle) Age ________ Sex __________

Address ______________________________ Zip__________ Telephone __________

School ______________________________ Grade _______ Nickname __________

Patient's Dentist ______________________________ Date of Last Dental Exam __________

Other family members or friends treated here? ______________________________

Parent or Guardian's Name ______________________________

Who can we thank for referring you to us? ______________________________

Responsible Party Information

Name ______________________________ (Last, First, Middle, Marital Status)

Residence ______________________________ (Street, City, State, Zip)

Mailing Address ______________________________ (Street, City, State, Zip)

How long at this Address ______________ Home Phone__________________ Work Phone__________________

Previous Address (if less than 3 years) ______________________________ (Street, City, State, Zip)

Social Security # ________________________ Birthdate______________ Relationship to Patient______________

Employer ________________________________ Occupation__________________ No. Years Employed_____

Spouse's Name ______________________________ (Last, First, Middle) Relationship to Patient______________

Employer ________________________________ Occupation__________________ No. Years Employed_____

Social Security #__________________________ Birthdate ____________ Work Phone __________________

Insurance Information

Insured's Name ______________________________ Insured's Soc. Sec. # ____________

Insurance Company________________________________ Group No.__________ Local No. ______________

Insurance Co. Address ______________________________

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name ______________________________ Insured's Soc. Sec. # ____________

Insurance Company________________________________ Group No.__________ Local No. ______________

Insurance Co. Address ______________________________

Insured's Employer ______________________________

Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ______________________________

Phone ______________________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor)______________________________

Updates (date & initial) ____________ ____________ ____________ ____________ ____________

MEDICAL HISTORY

Is Patient in good Health? ______________________ Yes ❐ No ❐

Does patient have any history of major illness? ______________ Yes ❐ No ❐

Has the patient ever been under the care of a physician for illness? _____ Yes ❐ No ❐

Please list: *check any of the following for which patient has been treated:*

Diabetes ❐	Anemia ❐	Prolonged Bleeding ❐
Pneumonia ❐	Epilepsy ❐	Fainting or Dizziness ❐
Heart Trouble ❐	Asthma ❐	Nervous Disorders ❐
Rheumatic Fever ❐	Kidney Involvement ❐	Liver Involvement ❐
Bone Disorders ❐	Tuberculosis ❐	Endocrine Problems ❐

Has patient tested positive for HIV or AIDS? Yes ❐ No ❐

Does patient have tendency to colds? ❐ Sore Throats? ❐ Ear Infections? ❐

Have tonsil and adenoids been removed? What age?__________ Yes ❐ No ❐

List any drugs or medications now being taken. Give reasons: ______________________

____

List any allergies or drug sensitivity______________________________

Has patient reached puberty? Girls - Has she started Menstruation _____ Yes ❐ No ❐

Boys - Has his voice changed _________ Yes ❐ No ❐

Height_____________ Weight_____________

DENTAL HISTORY

Has there been any injuries to face, mouth or teeth? ____________ Yes ❐ No ❐

Has the patient ever sucked a thumb or fingers? Until what age? ______ Yes ❐ No ❐

Does the patient have any speech problems? ______________ Yes ❐ No ❐

Is the patient a mouth breather? While Awake?______________ Yes ❐ No ❐

While Asleep? ______________ Yes ❐ No ❐

Have you been informed of any missing or extra permanent teeth? ______ Yes ❐ No ❐

Has an Orthodontist been consulted previously? ______________ Yes ❐ No ❐

Has either parent had orthodontic treatment? ______________ Yes ❐ No ❐

List any musical instruments played ______________________________

Reason for consultation______________________________

____

CLINICAL EXAM *(OFFICE USE ONLY)*

Name____

Profile______________ Skeletal Class ______________ Habits ______________

TMJ Noise R______L__________ Dental Class ______________ Missing Teeth ______________

Headache______________ Midline ______________ Oral Hygiene ______________

Deviation at opening __________ Perio______________________________

LM Palpation ______________ Comments:

____

Problems ______________

Prob X's ______________ Estimated Time__________ Approx Cost__________ Attitude__________

❐ Records Date Set-Up______________

❐ Lateral Head Film ❐ A-P Film ❐ Impressions ❐ Study Models *or* ❐ Other__________

❐ Panorex ❐ Sub Mental Vertex ❐ Transorbital ______________

❐ P.A.'s ❐ Photos ❐ MRI ❐ Other______________

____

Treatment: ____

____

____

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____

Parent's Signature