OoLi Valley Orthodontics
Tempe & Phoenix

W.W. Jonathan Park, DMD, MS
Specialist in Orthodontics

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____ Sex: M / F

SS#: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Mobile#: _____

Interest/Hobby: _____

Mother's Name: _____ Phone: _____ Occupation: _____

Father's Name: _____ Phone: _____ Occupation: _____

Other children in family (Name & Age): _____

● *MEDICAL HISTORY*

Physician: _____ Last Visit: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Are you under a physician's care presently? Y / N For what condition? _____

Medical History Updated: 0mo ( ) 6mo ( ) 12mo ( )
18mo ( ) 24mo ( ) 30mo ( ) 36mo ( )

Please indicate Yes or No to following medical conditions

Heart Disease -	Y / N	Thyroid Disease -	Y / N	Hepatitis / Jaundice -	Y / N
Heart Murmur -	Y / N	Kidney Disease -	Y / N	AIDS/HIV+ -	Y / N
Rheumatic Fever -	Y / N	Tuberculosis -	Y / N	Frequent Colds -	Y / N
Birth Defect -	Y / N	Blood / Bleeding Disorder -	Y / N	Nasal Blockage -	Y / N
Asthma -	Y / N	Seizures -	Y / N	Emotional Problem -	Y / N
High Blood Pressure -	Y / N	Arthritis -	Y / N	Psychiatric Therapy -	Y / N
Diabetes -	Y / N	Digestive Disorder -	Y / N	Drug/ Alcohol use -	Y / N
Unusual Childhood Disease -	Y / N	Other Major Illnesses -	Y / N	Hospitalization / Surgery -	Y / N

If you have answered YES to any of the above, please explain: _____

Are you taking any medications? Y / N What? _____

Do you have any allergies? Y / N Penicillin / Aspirin / Codeine / Novocain / Food / Metals / Others _____

For Woman: Are you pregnant? Y / N Are you taking birth control pills? Y / N

● *GENERAL INFORMATION*

Has the patient reached Puberty (Menstruation)? Y / N When? _____

Does the patient play any musical instruments? Y / N Which? _____

Does any relative have a similar bite? Y / N Who? _____ Patient looks like: Mom / Dad

Height: ____ ft ____ in. Father: ____ ft ____ in. Mother: ____ ft ____ in.

Natural / Adopted Child

Other relatives being treated here: _____

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- ***ORAL HEALTH HISTORY***

Family Dentist: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Last Visit: _____ Treatment Received: _____

Why are you seeking orthodontic treatment? **Health** / **Cosmetics** / **Psychological** / **Other** _____

What would you like to accomplish with orthodontic treatment? _____

Would you like improvement in facial appearance? Y / N How? _____

Whom may we thank for this referral? _____

Please indicate Yes or No to following conditions

Clicking of Jaw (TMJ) -	Y / N	Tongue Thrusting/Habit -	Y / N	Prior Orthodontic Treatment -	Y / N
Pain in Jaw/Ear -	Y / N	Grinding Teeth (Day / Night) -	Y / N	Extra Teeth -	Y / N
Injury to Teeth -	Y / N	Pen, Lip, or Nail Biting -	Y / N	Extraction of Teeth -	Y / N
Injury to Face -	Y / N	Thumb or Finger Sucking -	Y / N	Missing Teeth -	Y / N
Difficulty Chewing -	Y / N	Chewing Gum -	Y / N	Speech Problem -	Y / N
Fever Blisters/Ulcers -	Y / N	Mouth Breathing -	Y / N	Dry Mouth -	Y / N

If you have answered YES to any of the above, please explain: _____

Please list any other information, which you feel, may be of value in the treatment. _____

_____

- ***FINANCIAL***

Person responsible for finances: _____

Occupation: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Mobile#: _____

Orthodontic Coverage: Y / N

Percent Coverage: _____ % Maximum Benefit: $ _____ Patient Portion: $ _____

Insurance Company: _____

I.D. # _____ Group #: _____

- ***CONSENT***

To the best of my knowledge, all the preceding answers are true and correct.

Pt's/Pt's Parent Signature **Print Name** **Date**