WAGNER, KUNTZ & GRABOUSKI, P.C.

Practice Limited To Orthodontics

PATIENT INFORMATION

DATE

PATIENT'S FULL NAME	NICKNAME	BIRTHDATE	AGE	SEX
STREET ADDRESS/BOX NUMBER				
CITY		STATE	ZIP	
HOME PHONE NUMBER		WORK NUMBER		
SCHOOL		GRADE		

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER	
STREET ADDRESS/BOX NUMBER			
CITY		STATE	ZIP
HOME PHONE NUMBER			
EMPLOYER			
EMPLOYER'S ADDRESS			
WORK PHONE NUMBER AND EXTENSION			

FATHER'S ORTHODONTIC INSURANCE INFORMATION:

INSURANCE COMPANY NAME			INSURANCE CO. PHONE
INSURANCE COMPANY ADDRESS			
CITY	STATE	ZIP	POLICY #

MOTHER'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER	
STREET ADDRESS/BOX NUMBER			
CITY		STATE	ZIP
HOME PHONE NUMBER			
EMPLOYER			
EMPLOYER'S ADDRESS			
WORK PHONE NUMBER AND EXTENSION			

MOTHER'S ORTHODONTIC INSURANCE INFORMATION:

INSURANCE COMPANY NAME			INSURANCE CO. PHONE
INSURANCE COMPANY ADDRESS			
CITY	STATE	ZIP	POLICY #

IF COVERED BY MEDICAID PLEASE SHOW RECEPTIONIST YOUR CARD AND WRITE YOUR NUMBER HERE

PATIENT INFORMATION

FAMILY DENTIST

HAS ANY OTHER MEMBER OF THE FAMILY BEEN TREATED IN THIS OFFICE? IF SO, WHO?

WHOM MAY WE THANK FOR REFERRING YOU TO US?

HAS PATIENT EVER BEEN SEEN BY AN ORTHODONTIST?

DOES THE PATIENT HAVE A HISTORY OF THE FOLLOWING?

- RHEUMATIC FEVER ..... ❑ YES ❑ NO
- HIGH BLOOD PRESSURE ..... ❑ YES ❑ NO
- DIABETES ..... ❑ YES ❑ NO
- BLOOD DISORDERS ..... ❑ YES ❑ NO
- ALLERGIES ..... ❑ YES ❑ NO
- POPPING OR CLICKING OR PAIN WITH LOWER JAW MOVEMENT ..... ❑ YES ❑ NO
- TONSIL OR ADENOID PROBLEMS ..... ❑ YES ❑ NO
- IS PATIENT NOW TAKING ANY MEDICATION ..... ❑ YES ❑ NO
- FINGER OR THUMB SUCKING HABITS ..... ❑ YES ❑ NO
- IF YES, TO WHAT AGE? _____.

DOES ANY OTHER CONDITION EXIST OTHER THAN THOSE MENTIONED ABOVE?

REASON FOR SEEKING ORTHODONTIC TREATMENT?

DATE	INS. CODE:

DIAGNOSIS: CLASS I ☐ CLASS II ☐ CLASS III ☐

TREATMENT PLAN:

☐ SERIAL EXTRACTION
☐ EARLY FACE BOW

☐ NON-EXTRACTION
☐ EXTRACTION

☐ ONE ARCH
☐ BOTH ARCHES

ESTIMATED FOR _____

_____