

W. NETTLES GREEN, D.M.D., M.S.

WELCOME TO OUR OFFICE

— Please Print —

DATE OF BIRTH _____

DATE _____

Patient's Name _____ Age _____ Sex: Male Female
First Middle Last

Name Patient Prefers to be Called _____ Telephone Number _____

Home Address _____ Zip Code _____

Patient's Hobbies or Interests _____

Patient's Dentist _____ Date of Last Visit _____

IS THERE SOMEONE OTHER THAN YOUR DENTIST THAT WE MAY THANK FOR REFERRING YOU TO OUR OFFICE?

(FRIENDS, NEIGHBORS, PATIENTS, ETC.) _____

Patient's Occupation _____ SS# _____ Work Phone _____

Employer _____ Address _____ City _____

How long with this employer? _____

Marital Status: Married Divorced Separated Single Widowed

Spouse's Name _____ SS# _____ Work Phone _____

Spouse's Occupation _____ How long with present employer? _____

Spouse's Employer _____ Address _____ City _____

Person responsible for account _____ Phone _____

Responsible party's address _____ City _____ State _____ Zip _____

How long at this address? _____ Previous address (if less than 3 years) _____

Do you have insurance which covers orthodontics? _____ Insurance company name _____

Name of Insured _____ Group # _____ Insured's Date of Birth _____

Is the patient under the care of a physician for a specific problem at the present time? Yes No Illness _____

List any medicines your are currently taking _____

List any drug allergies _____

Is there a history of serious illness, accident or operation? _____

If so, list. _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

- Bone Disorder
- HIV/Aids
- Heart Trouble/Disease
- Kidney Disease
- Hepatitis/Liver Disease

- High Blood Pressure
- Head or Facial Injury
- Tonsillitis
- Hearing Disorder
- Ear Infections

- Allergies or Asthma
- Rheumatic Fever
- Diabetes
- Bleeding Problems
- Epilepsy

- Speech Problems
- Emotional Problems
- Endocrine Problems
- Nervous Disorders
- Adopted

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? _____ Yes No

Has the patient ever sucked a thumb or fingers? _____ Yes No

Until what age? _____

Has an orthodontist been consulted previously? _____ Yes No

Has the patient had any previous orthodontic treatment? _____ Yes No

If so, by whom? _____

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

Please list any family members previously treated here. _____

What is your main concern with your teeth? _____

THANK YOU



Signature _____