Name: DOB: Chart:

Wesslen Orthodontics

wesslenortho.com
info@wesslenortho.com

426 S. Garden Street • Visalia, CA 93277
office (559) 732-5658 *fax* (559) 732-1958

987 N. Blackstone Street • Tulare, CA 93274
office (559) 688-8969 *fax* (559) 684-1071

Patient Information (Confidential)

Patient Name _____ Date of Birth _____ Sex _____ Age _____

Address _____ Dentist _____ Physician _____

City _____ State _____ Zip _____ Referred to us by Friend / Dentist / Web / Facebook / Ot

Phone _____ _____

Cell _____ I am interested in appointment reminders by

Email _____ Email..... Yes No

Telephone..... Yes No

Cell Phone / SMS..... Yes No

I am interested in electronic statements..... Yes No

RESPONSIBLE PARTY

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Bus Phone _____

Cell _____

Email _____

Occupation _____

Employer _____

SPOUSE

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Bus Phone _____

Cell _____

Email _____

Occupation _____

Employer _____

INSURANCE INFORMATION

Primary Dental Insurance Co _____ Pri S.S.N/SI.N. _____ DOB _____

Primary Policy Holder's Name _____ Pri Group No. _____

Secondary Dental Insurance Co _____ Sec S.S.N/SI.N. _____ DOB _____

Secondary Policy Holder's Name _____ Sec Group No. _____

Who suggested that your child might need orthodontics? Insurance coverage for orthodontic treatment? Yes No

_____ % of fee covered _____ Lifetime Maximum _____

Foster Child.....Yes No S.S.N._____ Automatic Pmts: Yes No

Social Workers Name _____ We must bill: Yes No _____

Phone _____ Waiting Period: Yes No _____

The above information is complete to the best of my knowledge.

Date_____ Signature_____

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Health History Questionaire (Confidential)

1. Have you ever had any health problems in the past five (5) years? Yes No
2. Have you seen a physician or other health care provider in the past two (2) years? Yes No
3. Is there any activity your doctor says you cannot do? Yes No
4. Have you been hospitalized or had a serious illness in the past five (5) years? Yes No
5. Have you ever had a bleeding problem? Yes No

Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer the question.

Heart / Blood Vessels
Rheumatic fever Yes No
Rheumatic heart disease Yes No
Heart valve damage Yes No
Heart murmur Yes No
Congenital heart defect Yes No
Artifical heart valve Yes No
Prolapsed heart valve Yes No
High blood pressure Yes No
Heart attack (Date_____) Yes No
TIA/Stroke (Date_____) Yes No
Heart Surgery (Date_____) Yes No
Vascular Surgery (Date_____) Yes No
Pacemaker Yes No
Coronary Heart Disease Yes No
Congestive heart failure Yes No
Angina pectoris/chest pain Yes No
Irregular/rapid heart beats Yes No
Other heart or vessel disorder Yes No

Blood
Blood clots or thrombosis Yes No
Anemia Yes No
Sickle cell disease / trait Yes No
Hemophilia Yes No
Transfusion (Date_____) Yes No
Bruise easily for no apparent reason Yes No
Other blood disorder Yes No

Nervous System
Epilepsy Yes No
Siezure disorder Yes No
Multiple sclerosis Yes No
Trigeminal neuralgia Yes No
Chronic pain Yes No
Anxiety/depression Yes No
Alzheimer's disease/dimentia Yes No
Psychiatric treatment Yes No
Psychological counseling Yes No
Persistent dizziness/fainting spells Yes No
Persistent numbness/tingling Yes No
Other nervous system/mental disorder Yes No

Head and Neck
Glaucoma Yes No
Chronic sinusitis Yes No
Injury to head, neck, jaw or teeth Yes No
Headaches Yes No
Unexplained visual change Yes No
Frequent or severe nosebleeds Yes No
Persistent sore throat or hoarseness Yes No
Recurrent neckache or neck pain Yes No
Recent difficulty swallowing Yes No
Other head or neck disorder Yes No

Endocrine
Diabetes Yes No
Low thyroid Yes No
Other thyroid condition Yes No
Cushings syndrome Yes No
Parathyroid condition Yes No
Other endocrine condition Yes No

Musculoskeletal / Connective
Sjögren's syndrome Yes No
Arthritis Yes No
Artificial joint (Date_____) Yes No
Fibromyalgia/rheumatism Yes No
Chronic back pain Yes No
Other muscle or bone disorder Yes No

Respiratory
Tuberculosis (TB) Yes No
Asthma Yes No
Chronic bronchitis Yes No
Emphysema Yes No
Persistent cough Yes No
Cough up bloody sputum Yes No
Shortness of breath Yes No
Other respiratory disorder Yes No

Urinary Tract
Kidney disease Yes No
Renal dialysis Yes No
Venereal disease Yes No
Sexually transmitted disease Yes No
Other urinary disorder Yes No

Digestive System
Hepatitis Yes No
Cirrhosis of the liver/liver disease Yes No
Ulcers Yes No
Jaundice Yes No
Frequent Heartburn or reflux Yes No
Frequent nausea/vomiting Yes No
Other digestive disorder Yes No

Cancer History
Cancer Yes No
If yes, type?_____
Leukemia Yes No
Benign tumors/growths Yes No
Type of treatment
Surgery Yes No
Radiation therapy Yes No
Chemotherapy Yes No
Hormone therapy Yes No

Allergy History
Are you alergic to or have you ever had a bad reaction to any of the following?

Dental Anesthetics Yes No
Penicillin Yes No
Sulfa drugs Yes No
Other antibiotics Yes No
Aspirin Yes No
Latex products Yes No
Metals, including jewelry Yes No
Other allergy Yes No

Family History
Has anyone in your family (grandparent, parent, sibling, child) ever had:
Diabetes Yes No
Heart disease Yes No
Depression or anxiety Yes No
Tuberculosis Yes No
Any disorder that "runs in" your family Yes No

PLEASE CONTINUE . . .

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Health History Questionaire (Confidential, continued)

Dental

Difficulty opening jaw	Yes	No
TMD or TMJ problems	Yes	No
Extra or missing teeth	Yes	No
Chiped primary/adult teeth	Yes	No
Sensitive teeth (hot/cold)	Yes	No
Jaw Fractures / Cysts	Yes	No
Dead teeth / root canals	Yes	No
Bleeding gums / bad taste	Yes	No
Periodontal problems	Yes	No
Food impaction between teeth	Yes	No
Frequent canker/cold sores	Yes	No
Finger/thumb sucker	Yes	No
Age? _____		
Abnormal swallowing		
Speech problems	Yes	No
Snoring / mouth breathing	Yes	No
Jaw clenching or teeth grinding	Yes	No
Ringing in ears	Yes	No
Jaw locking/clicking	Yes	No
Previous treatment problems	Yes	No
Tonsil/adenoid conditions	Yes	No

Miscellaneous

Lupus erythematosus	Yes	No
Organ transplant	Yes	No
If yes, which?_____		
Supressed immune system	Yes	No
Persistent fever	Yes	No
Taken steroid/prednisone	Yes	No
Taken prescription diet pills	Yes	No
If yes, type?		
Pondimin	Yes	No
Redux	Yes	No
Phen-fen	Yes	No
Other_____		
Used tobacco products	Yes	No
If yes, type?_____		
How much?_____		
How long?_____		
Still using	Yes	No
Would like to quit	Yes	No
Quit on (Date_____)		
Drink alcoholic beverages	Yes	No
How much?_____		
Used methamphetamine amphetamines/"speed"	Yes	No
Used intravenous drugs	Yes	No
Used cocaine or "crack"	Yes	No
Used any other recreational drug	Yes	No
Are you a recovering alcoholic or addict?	Yes	No

Miscellaneous cont.

Birth defects	Yes	No
Aids/HIV Positive	Yes	No
Bone Fractures	Yes	No
Skin Disorders	Yes	No

Women Only

Started menstruation?	Yes	No
Are you pregnant or is there a chance you may be pregnant?	Yes	No
Are you breast feeding?	Yes	No
Are you in or have you passed through menopause?	Yes	No

Do you have any other condition that you think we should know about?... Yes No

_____

Please circle all the medications you are currently taking:

Heart	Blood Thinners	Hormones	Antibiotics
Nitroglycerin	Blood Pressure	Insulin/diabetic drugs	Antihistamine
Digitalis	Oral Contraceptive	Thyroid	Cyclosporin A
Aspirin(__tab/day)	Steroids/Cortisone	Nifedipine	
Tranquilizers	Antidepressants	Pain	

Please list medication names and dosages

Name	**Dosage**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have read and understand the above questions. I will not hold my orthodontist or his staff responsible for any errors or omissions I have made in the completion of this form. If there are any medical/dental changes in the future, I will inform this office.

_____ _____
Signature of Patient, Parent, or Guardian Date

_____ _____
Todd E Wesslen, DDS, MS Date