Date of Exam ___________________

Wayne N. Wyatt, DDS, MS, PC

Patient ______________________________

Age ________ Date of Birth ______________ Gender M / F

Home Address ______________________________

City ____________________ State ____ Zip ________

Phone Home _______________ Cell _______________

Hobbies / Interests ______________________________

School ______________________________ Grade ________

Siblings (ages) ______________________________

Mother ______________________________

Phone Home _______________ Cell _______________

Work _______________

Social Security No. ______________________________

Father ______________________________

Phone Home _______________ Cell _______________

Work _______________

Social Security No.

Current Dentist ______________________________

How did you hear about us?

- ☐ Friend _______________
- ☐ Family _______________
- ☐ Dentist _______________
- ☐ Former Patient _______________
- ☐ Internet
- ☐ Insurance Company
- ☐ Yellow Pages
- ☐ Other _______________

Responsible party

Name ______________________________

Relation to Patient ______________________________

Billing Address ______________________________

City _______________ State _____ Zip ________

Phone Home _______________ Cell _______________

Work _______________

Social Security No. ______________________________

Employer ______________________________

Have you ever had any of these diseases or medical problems?

Y N **Heart Murmur**

Y N **HIV+ / AIDS**

Y N **Diabetes**

Y N **Artificial Valves**

Y N **Hepatitis**

Y N **Epilepsy/Seizures/Fainting Spells**

Y N **Tuberculosis (TB)**

Y N **Mitral Valve Prolapse**

Y N **Hemophilia / Abnormal Bleeding**

Y N **Severe / Frequent Headaches**

Any other medical problems / diseases? _______________

Are you ALLERGIC to any of the following?

Y N **Penicillin**

Y N **Aspirin**

Y N **Codeine**

Y N **Latex**

Y N **Any metal / plastic**

Y N **Other** _______________

Any other allergies or drug sensitivities? _______________

What are your main concerns regarding your teeth?

ORTHODONTIC INSURANCE

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Date of Birth		Date of Birth	
Subscriber ID/SSN		Subscriber ID/SSN	

I authorize Wayne N. Wyatt, DDS, MS, PC to file benefit claims on my behalf. ______________________________ Date _______________

Patient / Guardian

- - - - - - - - - - For Office Use Only - - - - - - - - - -

I verbally reviewed the medical / dental information above with the patient named herein. *Initials* ____________ *Date* _______________

Doctor's Comments: ______________________________

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Extractions: _______________ *Est. Tx Time*: _______________ *Fee (Range)* _______________