ROGER L. BOOKWALTER, D.D.S., M.S.
CYNTHIA L. FEE, D.D.S., M.S.
NICOLE S. WRIGHT, D.D.S., M.S.

BOOKWALTER, FEE & WRIGHT

PROFILES IN ORTHODONTICS

We welcome you and your child to our office. Please provide the following information and bring it with you to your next appointment.

Patient's Name_____ Prefers to be called _____ Birth Date ____/____/____

Age _____ Gender ____ ☐ Male ☐ Female Primary phone_____

Home Address _____
Street *City* *State* *Zip*

School_____ Sports/Hobbies_____

Siblings *Name, Age* _____

Other family members that have been seen in our office_____

How did you hear about us? ☐ Dentist ☐ Family ☐ Friend ☐ Website ☐ Other _____ Referred by_____

RESPONSIBLE PARTY INFORMATION

PARENT _____ Address_____
Mr./Ms./Mrs./Dr. *Street* *City* *State* *Zip*

Home Phone_____ Cell Phone_____ Work Phone_____ Email_____

PARENT _____ Address_____
Mr./Ms./Mrs./Dr. *Street* *City* *State* *Zip*

Home Phone_____ Cell Phone_____ Work Phone_____ Email_____

LEGAL GUARDIAN *(if not parent)*_____ Address_____
Street *City* *State* *Zip*

Home Phone_____ Cell Phone_____ Work Phone_____ Email_____

PRIMARY DENTAL INSURANCE

Insured's Name_____

Employer_____

Relationship to patient_____ Insured's Birth Date_____

Insured's Social Security or ID # _____

Name of Insurance Company_____

Group #_____

ADDITIONAL DENTAL INSURANCE

Insured's Name_____

Employer_____

Relationship to patient_____ Insured's Birth Date_____

Insured's Social Security or ID # _____

Name of Insurance Company_____

Group #_____

I understand that insurance claims will be submitted by Dr's. Bookwalter, Fee and Wright's office. I understand that I am responsible for all charges not paid by my insurance. I authorize release of any information relating to this claim to the insurance carrier.

SIGNATURE_____ **DATE**_____ **OVER →**

9416 SOUTH MAIN STREET SUITE 111 PLYMOUTH, MICHIGAN 48170 P 734.455.2323 F 734.455.8033

Patient's Name:_____

Medical History

Primary Care Physician_____

Date of Last Visit_____ Phone_____

Please check any of the following medical conditions for which your child has been treated:

- ☐ Adenoids removed
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder
- ☐ Autism/Asperger's Syndrome
- ☐ Benign Tumor
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Epilepsy/Seizures
- ☐ Gastrointestinal Disorders
- ☐ Headache/Migraine
- ☐ Heart condition
- ☐ Head/Facial Injury
- ☐ Hemophilia/Bleeding disorder
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney/Liver Disease
- ☐ Oral Ulcers
- ☐ Previous surgery
- ☐ Nervous Disorder
- ☐ Radiation/Chemotherapy
- ☐ Thyroid problems
- ☐ Tonsils removed
- ☐ Tuberculosis

Other medical or behavioral concerns not listed above that you feel we should be aware of?

_____

_____

_____

	YES	NO
Is the patient taking any medications?	☐	☐

*Please list medications and purpose*_____

_____

_____

Is the patient allergic to any medications?	☐	☐

*Please list medications*_____

_____

_____

Does the patient have any other allergies?	☐	☐

*Please specify*_____

Does the patient require antibiotic pre-medication for dental procedures?	☐	☐
Has the patient reached puberty? *(menstruation, voice changes, facial hair)*	☐	☐

Estimate of patient's height potential_____

Is the patient adopted?	☐	☐

Dental History

General Dentist_____

Date of Last Visit_____Phone_____

Address_____

	YES	NO
Has the patient had any teeth extracted?	☐	☐

*Please specify*_____

Has the patient ever been informed of having any missing or extra teeth?	☐	☐
Has the patient had any injuries to teeth, mouth, or jaws?	☐	☐

*Please explain*_____

Does the patient grind or clench his/her teeth?	☐	☐
Does the patient's jaw ever click or get sore?	☐	☐
Does the patient have trouble opening wide or to the side?	☐	☐
Does the patient have any speech problems?	☐	☐

*Please explain*_____

Does the patient have any oral habits? *(Thumb/finger/lip sucking, tongue thrust, nail biting)*	☐	☐

*Please specify*_____

Any family history of severe orthodontic problems or "jaw surgery"?	☐	☐
Has the patient had previous orthodontic treatment or an orthodontic consultation?	☐	☐

Date_____Dr._____

City, State_____

Reason for seeking this consultation?_____

_____

_____

_____

_____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

_____

Update Signature Date