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

Patient's Name _____ Prefer to be called _____
Mr. Mrs. Ms. Dr.

Birth date ____/____/____ Age ____ ☐ Male ☐ Female

Home Address _____
Street City State Zip

Home Phone_____ Cell Phone_____ Work Phone _____ Email_____

Employer _____ Occupation _____

Please indicate the email address you prefer we use for appointment confirmation _____

Other family members that have been seen in our office _____

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

PRIMARY DENTAL INSURANCE

Insured's Name _____

Relationship to patient _____ Insured's Birth date _____

Insured's Social Security or ID # _____

Name of Insurance Company _____

Orthodontic Insurance Benefits _____

ADDITIONAL DENTAL INSURANCE

Insured's Name _____

Relationship to patient _____ Insured's Birth date _____

Insured's Social Security or ID # _____

Name of Insurance Company _____

Orthodontic Insurance Benefits _____

I understand that insurance claims will be submitted by Drs. 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 _____

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 you 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
Are you taking any medications?	☐	☐

Please list medications _____

_____

_____

Are you allergic to any medications?	☐	☐

Please list medications _____

_____

Do you have any other allergies?	☐	☐

Please specify _____

Do you require antibiotic pre-medication for dental procedures?	☐	☐

Please specify _____

Are you pregnant?	☐	☐

DENTAL HISTORY

General Dentist _____

Date of Last Visit _____ Phone _____

Address _____

	YES	NO
Have you ever had any teeth extracted?	☐	☐
Have you ever been informed of having any missing or extra teeth ?	☐	☐
Have you had any injuries to teeth, mouth, or jaws?	☐	☐

Please explain _____

Do you have difficulty chewing or swallowing?	☐	☐

Please explain _____

Do you grind or clench your teeth?	☐	☐
Do you have pain in your jaw?	☐	☐
Does your jaw ever lock open?	☐	☐
Do you have any speech problems?	☐	☐

Please explain _____

Do you have any oral habits? *(Lip sucking, tongue thrust, nail biting)*	☐	☐

Please specify _____

Please describe any previous orthodontic treatment, if any (duration, extent, upper/lower, length of treatment)

_____

_____

_____

Date _____ Dr. _____

City, State _____

Reason for seeking this consultation? _____

_____

_____

_____

SIGNATURE OF RESPONSIBLE PARTY

_____

DATE