



Carl K. Walker, D.M.D., M.S.

PATIENT

Full Name _____ Nickname _____ Date _____

Address _____ Phone (Hm & Cell) _____

City/State _____ Zipcode _____

Birthdate _____ Age _____ Sex _____ School Name _____ Grade _____

Sports or Hobbies _____ # of Siblings & Ages _____

Dentist Name _____ Phone _____

Physician Name _____ Phone _____ Referral Source _____

SELF/RESPONSIBLE PARTY INFORMATION

SPOUSE/SECOND PARENT INFORMATION

Name _____

Name _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Hm Phone _____ Cell Phone _____

Hm Phone _____ Cell Phone _____

Birthdate _____ Age _____ Marital Status _____

Birthdate _____ Age _____ Marital Status _____

DL # _____

DL# _____

SS # _____

SS # _____

Employer _____

Employer _____

Employer Address _____

Employer Address _____

City/State/Zip _____

City/State/Zip _____

Work Phone _____ Years Employed _____

Work Phone _____ Years Employed _____

Occupation _____

Occupation _____

INSURANCE INFORMATION

For most orthodontics, you **MUST** have an orthodontic rider on your dental insurance. We are happy to file your primary insurance as a courtesy; however, payments will be paid directly to you. Payment for services rendered is due in full at time of service.

Insurance Company _____ Phone _____

Address _____

City/State/Zip _____ Lifetime Maximum _____

Contract/Policy ID # _____ Group # _____

I understand that where appropriate, credit bureau reports may be obtained.

Patient /Parent Signature _____

MEDICAL HISTORY

Frequent or Severe Headaches	Y N	Heart Murmur	Y N	Fever blisters/current or past	Y N
Heart disease	Y N	Joint problems	Y N	Yellow Jaundice	Y N
Sinus/Respiratory disease	Y N	Hepatitis	Y N	Measles/Mumps/Chicken Pox	Y N
Blood disease	Y N	Polio	Y N	Pregnant	Y N
Liver disease	Y N	Diabetes	Y N	History of Fainting/Dizziness	Y N
Thyroid disease	Y N	Anemia	Y N	Drug Addiction	Y N
Kidney disease	Y N	Mononucleosis	Y N	Radiation Therapy	Y N
HIV positive	Y N	Hemophilia	Y N	Chemical Therapy	Y N
Venereal disease	Y N	Emphysema	Y N	Blood Transfusions	Y N
Intestinal disease	Y N	Epilepsy	Y N	Smoke	Y N
Bone disease	Y N	Rheumatic/Yellow/Scarlet Fever	Y N	(Females) Menstruation	Y N
Nervous/emotional problems	Y N	Acquired Immune Deficiency	Y N	(Males) Shaving	Y N
High/Low Blood Pressure	Y N	Rheumatism or Arthritis	Y N	Physical within one year	Y N
Endocrine Problems	Y N	Asthma or Hay fever	Y N	Height & weight normal for Age	Y N
Problems w/wounds healing	Y N	Tuberculosis	Y N	Latex Allergy	Y N
Tumors or Cancer	Y N	Broken Bones	Y N	Nickel Allergy	Y N
Frequent sore throats	Y N	Prolonged Bleeding	Y N	Autism (detail below)	Y N

Medication Allergy Y N Explain _____

List any regular medications _____

Anything else we need to know? _____

DENTAL HISTORY

Dental checkup in last year	Y N	Cheek/tongue/lip chewing	Y N	Clenching teeth	Y N
Clicking or discomfort in/near ears	Y N	Thumb sucking	Y N	Tongue thrusting	Y N
Face/mouth/teeth/injuries	Y N	Mouth breathing	Y N	Grinding teeth	Y N
Missing or extra permanent teeth	Y N	Nail biting	Y N	Speech problems	Y N
Gum problems	Y N	Previous orthodontic evaluation	Y N		
Tonsils or adenoids removed	Y N				

Have any other members of family had orthodontic treatment? _____ If so, when? _____

Were you happy with the results? _____ If not, why not? _____

Is patient happy with his/her smile? _____

Describe your orthodontic problem? _____

What would you like your orthodontic treatment to accomplish? _____