



Date of Exam _____

Patient Name: _____
 Age _____ Date of Birth _____ Gender _____
 Home Address _____
 City _____ State _____ Zip _____
 School _____ Grade _____
 Hobbies/Interests _____

Responsible Party/Guarantor:
 Name _____
 Relation to Patient _____
Billing Address
 (If Different) _____
 City _____ State _____ Zip _____
Social Security No. _____
Employer _____
Phone (Please circle preferred contact number):
 Home _____ Cell _____
 Work _____
Email Address:

Are you ALLERGIC to any of the following?
 _____ Latex _____ Penicillin
 _____ Aspirin _____ Any metal / plastic
 _____ Codeine _____ Other _____
Have you ever had any of these diseases or medical problems?
 _____ Heart Murmur _____ Epilepsy/Seizures/Fainting
 _____ HIV+ / AIDS _____ Tuberculosis (TB)
 _____ Diabetes _____ Mitral Valve Prolapse
 _____ Artificial Valves _____ Hemophilia / Blood disorder
 _____ Hepatitis _____ Severe / Frequent Headaches
 Any other medical problems / diseases? _____

How did you hear about our office?
 Friend _____
 Dentist _____
 Internet _____
 Insurance _____

Current Dentist _____
What are your main concerns regarding your teeth?

Please list any family members who have been patients in our office:

Name	Relationship
_____	_____
_____	_____

*****Please let our staff know if you have an orthodontic insurance policy that you would like for us to check for you.**

*****For Office use only-Do not write below this line*****

1. Skeletal: _____	7. Crossbite: Ant Post (Rt Lt Bilat) _____	
2. Class: I II III E/E Div: _____		
3. Overbite: Deep Imping Open _____ mm	8. Impacted teeth: _____	
4. Overjet: Norm Mod. Severe _____ mm	9. TMJ: _____	Est. Tx Time: _____
Underbite	10. Habits: _____	Tx Plan: _____
5. Crowding: _____	11. Midline: _____	
Upper: Minor Moderate Severe	12. Other: _____	Extractions: _____
Lower: Minor Moderate Severe		Appliances: _____
6. Spacing: _____		Fee: _____
REEX: _____		
		Chart #: _____
		SC#: _____



WYATT ORTHODONTICS
WAYNE N WYATT, DDS, MS, PC
Tulsa / Claremore / Sand Springs

Patient Name: _____

Date: _____

Signature: _____

I consent for the office of Wyatt Orthodontics, to share my personal and financial information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____



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Tulsa / Claremore / Sand Springs

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Wyatt Orthodontics Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Please Print Name

Signature of Patient / Parent / Guardian

Date

Expiration -- 3 Years from Initial Signature: _____
Date

Expiration -- Change in Insurance Coverage

Expiration -- Patient reaches the age of 18: _____
Date of Age 18