WESTLAKE
5656 Bee Cave Road, Ste C-100
Austin, Texas 78746
(512) 732-2500

STEINER RANCH
4302 N. Quinlan Park Road
Austin, Texas 78732
(512) 266-8585

CENTRAL
1814 W. 35th Street
Austin, Texas 78703
(512) 451-6457

WWW.WESTLAKEFAMILYORTHO.COM

Patient Name: _____ Nickname: _____ DOB: _____

Address: _____ City/ State/ Zip: _____

Email: _____ Cell Phone: _____

Whom may we thank for referring you: _____

Dental Insurance Information: (This may differ from your medical insurance.)

Name of Insurance Company: _____ Phone: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Relationship to Patient: (Circle One) Parent/Guardian Self Partner/Spouse

Member ID/SSN: _____ Group/Policy Number: _____

Name of Employer: _____

Dental History:

Main concern(s) for today's visit: _____

Dentist Name: _____ Date of last check-up: _____

Do you have any dental treatment to be completed? _____

Have you ever had or been evaluated for orthodontic treatment? _____

What options are you interested in to straighten your teeth? (Circle all that apply)

Metal Braces Clear Braces Invisalign Replace Retainers only

Have you ever had an unfavorable experience associated with dental work? _____

Have you ever had an injury to your mouth, teeth, or chin? _____

Are you aware of any missing or extra permanent teeth? _____

(continued on back) →

Medical History:

Are you taking any prescription / over-the-counter drugs? _____

If so, please list each: _____

Have you ever had any of the following medical concerns? (Please check all that apply)

o Bleeding disorder o Anemia o Artificial bones, joints, valves o Blood transfusion o Cancer/ chemotherapy o Congenital heart defects o Diabetes o Drug Abuse	o Asthma or Emphysema o Epilepsy / seizures o Fever blisters / Herpes o Glaucoma o Heart murmur / Pacemaker o High / Low blood pressure o HIV /AIDS o Kidney problems	o Mental health disorder o Migraines / severe headaches o Shingles o Sickle Cell disease o Tuberculosis o Ulcers / Colitis o Other (please explain):

Are there any other medical concerns that you would like us to be aware of? _____

_____

Are you allergic to any of the following? (Please check all that apply)

o Aspirin o Metals or Plastics o Codeine o Dental Anesthetics o Erythromycin	o Latex o Penicillin o Tetracycline o Other (please indicate):

Emergency Contact:

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relationship: _____

Cell Phone: _____ Other Phone: _____

Thank you for filling out this form completely.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date