# Coastal Carolina Orthodontics

## Adolescent and Adult Orthodontics


W. Alex Willis, D.D.S., M.Sc.O. ABO
Richard J. Vanek, D.D.S., M.Sc.O.
Raymond C. Ball, Jr., D.D.S., M.S. ABO
Todd A. Fischer, D.M.D., M.S. ABO
Benjamin J. Richards, D.M.D. ABO
David G. Walker, D.D.S., M.S. ABO
www.smilemakersnc.com


The Smile Makers at Coastal Carolina Orthodontics
Jacksonville Morehead City Havelock

### Adolescent Patient Begin Here

Name: _____ (First / MI / Last)
Address: _____
City: _____ State: _____ Zip: _____
Birthdate: _____ Sex: _____ Age: _____
Phone #: _____ School: _____

**FATHER INFORMATION**

☐ Father ☐ Stepfather ☐ Guardian ☐ Responsible Party

Name: _____ (First / MI / Last)
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Work Phone #: _____
Cell #: _____ ☐ Check box if you would like text message for appt reminders.
Employer: _____
SS #: _____ Birthdate: _____
Email Address: _____

**MOTHER INFORMATION**

☐ Mother ☐ Stepmother ☐ Guardian ☐ Responsible Party

Name: _____ (First / MI / Last)
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Work Phone #: _____
Cell #: _____ ☐ Check box if you would like text message for appt reminders.
Employer: _____
SS #: _____ Birthdate: _____
Email Address: _____

### Insurance Company Information

Insurance Company Name: _____

### Adult Patient Begin Here

Name: _____ (First / MI / Last)
Address: _____
City: _____ State: _____ Zip: _____
Birthdate: _____ Sex: _____ Age: _____
Employer: _____
Phone #: _____ Work Phone #: _____
Cell #: _____ SS #: _____
Email Address: _____
☐ Check box if you would like text message for appt reminders.

**SPOUSE INFORMATION**

Name: _____ (First / MI / Last)
Employer: _____
Work Phone #: _____ Cell #: _____
SS #: _____ Birthdate: _____

### Dentist & Physician Information

Dentist Name: _____
Physician Name: _____
Who referred you to our office: _____

### Nearest Relative Not Living With You

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Work Phone #: _____

## Medical History

| | YES | NO |
|---|---|---|
| Are you in Good Health: | | |
| Have you had a Physical Exam this year: | | |
| Are you under Medical Care: | | |
| Are you taking any Medications: | | |
| If YES, what: _____ | | |
| Are you Allergic to anything: | | |
| If YES, what: _____ | | |
| Are you Pregnant: | | |
| Do you Smoke: | | |

| | YES | NO |
|---|---|---|
| Do you have or have you had any of the following conditions or treatments: | | |
| Prosthetic Joint Replacement within the past 2 yrs: | | |
| Previous Prosthetic Joint Infection or Inflammation: | | |
| Mononucleosis: | | |
| Frequent Fever Blisters: | | |
| Rheumatism or Arthritis: | | |
| Epilepsy: | | |
| Diabetes: | | |
| Any Respiratory Disease: | | |
| Asthma or Hay Fever: | | |
| Prosthetic Heart Valves or Shunts: | | |
| History of Bacterial Endocarditis: | | |
| Cyanotic Heart Disease: | | |
| Congenital Heart Defect: | | |
| Heart Transplant: | | |

| | YES | NO |
|---|---|---|
| Any High / Low Blood Pressure: | | |
| Undergoing Hemodialysis: | | |
| History of Splenectomy: | | |
| Any Blood Disease: | | |
| Hemophilia: | | |
| Hepatitis: | | |
| Any Liver Disease: | | |
| Any Kidney Disease: | | |
| Any Tumors or Cancer: | | |
| Are you undergoing Chemo: | | |
| Acquired immune Deficiency Syndrome: | | |
| Any Hearing Problems: | | |
| Are you aware of any other Disease, Condition, or Problem, not listed above, that we should know about: | | |
| If YES, what: _____ | | |

## Dental History

| | YES | NO |
|---|---|---|
| Have you seen a General Dentist in the Last Year: | | |
| Do your jaw joints make a clicking or popping noise: | | |
| Do you find it difficult to open your mouth wide: | | |
| Has your jaw ever locked open so that you cannot close it: | | |
| Does it hurt when you chew or use your jaws: | | |
| Do you have a pain in front of your ears or ear pain: | | |
| Do you suffer from headaches: | | |
| Does your bite feel uncomfortable: | | |
| Do you clench or grind your teeth during the day: | | |
| Do you clench or grind your teeth during sleep: | | |
| Has your Mouth, Face or Teeth been injured by a Fall or Accident: | | |

| | YES | NO |
|---|---|---|
| Have you been informed of Missing or Extra Teeth: | | |
| Has your Doctor ever advised Antibiotics before a Dental Exam: | | |
| Have your Tonsils or Adenoids been removed: | | |
| Do you have any of the following habits: | | |
| Thumb or Finger Sucking: | | |
| Cheek, Tongue or Lip Chewing: | | |
| Mouth Breathing: | | |
| Fingernail Biting: | | |
| Speech Problems: | | |
| Have you been Examined by an Orthodontist before: | | |
| If YES / when: _____ | | |

## Acknowledgement of Receipt of Notice of Privacy Practices

☐ (check box) I acknowledge that I have the right to receive a copy of the Notice of Privacy Practices of Coastal Carolina Orthodontics

Patient, Parent or Guardian's Signature _____

*(Sign)* *(Print)* *(Date)*

I request that payment of authorized benefits be made either to me or on my behalf to Willis, Vanek, Ball, Fischer, Richards & Walker, P.A., for any services furnished me by that provider, realizing I am responsible to pay noncovered services. I hereby authorize any holder of information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

**I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENT.**

**SIGNATURE** _____ **DATE** _____

FOR OFFICE USE ONLY:

Date of First Visit: