Robert G. Winnard, D.M.D.

410-551-9531

1215 Annapolis Rd., Ste. 207
Odenton, MD 21113

1606 Forest Drive
Annapolis, MD 21403

ORTHODONTIC PATIENT INFORMATION

PLEASE FILL OUT BOTH SIDES COMPLETELY

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodontist to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, is important for our records and your health, is confidential. Please circle the appropriate response where indicated. ***Thank You***

Patient's Name _____ S.S. #_____ Age_____ Birthdate_____ Sex_____

Gender Identifies As: □ Female □ Male □ Non-Binary Preferred Pronouns: □ He/Him □ She/Her □ They/Them □ Other

Employer_____ Occupation _____ Email _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____Business Phone_____

IF ADULT, PLEASE DISREGARD PARENTS NAMES

Father's Name_____ S.S. #_____ Home Phone_____

Employer_____ Occupation _____ Business Phone _____

Mother's Name_____ S.S. #_____ Home Phone_____

Employer_____ Occupation _____ Business Phone _____

Person responsible for account: _____

Address_____ City _____ State _____ Zip _____

Is patient covered by insurance for orthodontic treatment? □ Yes □ No

If yes, by which company? _____ Insurance Phone #_____ ID #_____

Subscriber Name_____ Birthdate_____ Employer_____

Emergency Contact (Nearest relative not living with you)

Name_____ Relationship_____

Address_____ Phone_____

Family Dentist_____ Family Physician_____ Referred by_____

Other family members with similar orthodontic condition?

Father Mother Brother Sister Other Specify_____

MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor Under Treatment: □ Yes □ No

Specify:_____

Present Drugs or Medication: □ Yes □ No
Specify:_____

Has patient been under care of a physician during the past two years other than for routine examination? □ Yes □ No

Birth Defects □ Yes □ No
Specify:_____

The following conditions are of interest to the orthodontist.

Has the patient ever had:

□ Asthma	□ Diabetes	□ Heart Disease
□ Anemia	□ Epilepsy	□ Hearing Disorder
□ Blood Disease	□ Endocrine Problems	□ Head or Face Injury
□ Bone Disorders	□ Emotional Problems	□ Rheumatic Fever
□ AIDS/HIV - Infection		

Comments:
_____

Does the patient:

1. Have allergies to: Metals_____ Food_____ Drugs_____
2. Breathe through mouth? □ Seldom □ Sometimes □ Usually Comments_____
3. Have frequent sore throat or tonsillitis? □ Yes □ No
4. Have chewing or swallowing difficulty? □ Yes □ No

Has the patient received medical treatment from allergist or ear, nose, throat specialist? □ Yes □ No

If Yes: When:_____ By Whom:_____

Tonsils removed:_____ Adenoids removed:_____

Does the patient have pain or clicking in jaw point? □ Yes □ No

Have any teeth been injured due to accidents or blow to the mouth? □ Yes □ No

Has the patient received or been requested to receive speech correction? □ Yes □ No

Has the patient received or requested to receive treatment to TMJ? □ Yes □ No

Thumb sucking until age_____ Grinding teeth □ Yes □ No

Finger sucking until age _____ Tongue thrusting □ Yes □ No

Lip-biting or sucking? □ Yes □ No Other habits □ Yes □ No

Has the patient had any unusual dental experiences? □ Yes □ No

Specify:_____

Has the patient had previous orthodontic consultation or treatment? □ Yes □ No

Date:_____ Dr.:_____

Are there any other medical, dental or surgical problems not covered above? □ Yes □ No

If yes, explain:_____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT:

Is the patient aware of any orthodontic problem? □ Yes □ No

Patient's interest in orthodontic treatment:

Patient wants treatment Unwilling but agrees Uncooperative

Orthodontic consultation prompted by: Patient Dentist Mother Father Spouse Sibling

Physician Friend Other: (specify)_____

Why did the patient seek this consultation?_____

What is the primary problem?_____

Signature of individual completing this form:_____

Relationship to patient:_____ Date:_____