



ORTHODONTICS

DAN F. SHAW DMD, PS

Welcome!

The benefits of a happy, healthy smile are immeasurable! The information you provide is important for a thorough evaluation, and needs to be updated as changes occur. Please fill out both sides of this form completely.

Patient Information

Name _____ Preferred name _____
 Birthdate _____ Sex _____ Age _____ Phone () _____
 Address _____ City/State/Zip _____
 Physician _____ Phone () _____
 Dentist _____ Phone () _____
 Whom may we thank for referring you? _____
 Other family members seen at our office _____
 Emergency contact _____ Phone () _____

If you would like to communicate with us via email, please enter your preferred address(es) below:

Parent/Guardian Information (if patient is a dependent)

Marital status Married Widowed Separated Divorced Other _____
 Patient lives with Both parents Father Mother Other _____

Father Stepfather Guardian Other _____
 Name _____
 Address _____
 City/State/Zip _____
 Home phone () _____
 Work phone () _____
 Social Security # _____
 Occupation _____
 Employer _____
 Business address _____
 How long at current job? _____

Mother Stepmother Guardian Other _____
 Name _____
 Address _____
 City/State/Zip _____
 Home phone () _____
 Work phone () _____
 Social Security # _____
 Occupation _____
 Employer _____
 Business address _____
 How long at current job? _____

Employment Information (if patient is an adult)

Your occupation _____ Work phone () _____ Social security # _____
 Employer _____ Business address _____
 Spouse's name _____ Work phone () _____ Social Security# _____
 Employer _____ Business address _____
 If another person will be helping with this account, please provide his/her information below
 Name _____ Home phone () _____ Relationship to patient _____
 Occupation _____ Employer _____ Social Security # _____
 Work phone () _____ Business address _____

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Member American Association of Orthodontists



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Insurance Information

Primary insurance company _____ Secondary insurance company _____
Address _____ Address _____
Group# _____ Phone () _____ Group# _____ Phone () _____
Insured person's name _____ Insured person's name _____
Birthdate of insured _____ Birthdate of insured _____
Social Security # or I.D. # _____ Social Security # or I.D. # _____

Medical Health History

Are you presently under the care of a physician? Yes No

If yes, reason _____

Recent medications _____

Have you ever had or experienced any of the following?

Cancer/Tumor Yes No
Abnormal bleeding Yes No
Hepatitis, jaundice or liver trouble Yes No
Nervous disorder Yes No
Learning disability Yes No
AIDS/HIV+ Yes No
Tonsils and/or adenoids removed Yes No
Fainting spells, seizures or epilepsy Yes No
Diabetes Yes No
Smoking and/or chewing tobacco use Yes No
Congenital heart defect Yes No
Blood pressure problem Yes No
Heart murmur Yes No
Heart valve problem/replacement Yes No
Taking heart medication Yes No
Rheumatic fever Yes No
Artificial heart valve Yes No
Arthritis Yes No
Bone or joint surgery Yes No
Bone disorder Yes No

Are antibiotics required before treatment? Yes No

Allergies/adverse reactions?

Skin rashes Yes No
Asthma Yes No
Local anesthetics (*novacaine*) Yes No
Codeine Yes No
Metals Yes No
Penicillin Yes No
Latex Yes No
Other _____

Women

Please keep us advised of any pregnancies.

Additional notes _____

Dental Health History

Have you ever had or experienced any of the following?

Problems with previous dental treatment Yes No
Missing or extra permanent teeth Yes No
Previous orthodontic consultation or treatment Yes No
Mouth-breathing habit Yes No
Slow healing sores in or about the mouth Yes No
Thumb/finger sucking Yes No
Painful to chew Yes No
Trauma to the face, mouth, teeth or jaw(s) Yes No
Has your jaw ever locked Yes No

Approximate date of last cleaning _____

Additional notes _____

Any disease, condition or problem not listed previously that we should know about? Yes No

If yes, please describe _____

Reason for seeking orthodontic treatment _____

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

Signature _____ Relationship to patient _____ Date _____