WYATT ORTHODONTICS
LOVE YOUR SMILE

Wayne N Wyatt, DDS, MS, PC

Date of Exam _____

Patient Name: _____

Age_____ Date of Birth_____ Gender ___

Home Address_____

City_____ State_____ Zip_____

School_____ Grade _____

Hobbies/Interests _____

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? _____

Current Dentist _____

What are your main concerns regarding your teeth?

_____

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:

_____

How did you hear about our office?

☐ Friend _____

☐ Dentist _____

☐ Internet _____

☐ Insurance _____

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: _____

2. Class: I II III E/E Div:_____

3. Overbite: Deep Imping Open ____ mm

4. Overjet: Norm Mod. Severe ____mm

Underbite

5. Crowding:

Upper: Minor Moderate Severe

Lower: Minor Moderate Severe

6. Spacing: _____

7. Crossbite: Ant Post (Rt Lt Bilat) _____

_____

8. Impacted teeth: _____

9. TMJ: _____

10. Habits: _____

11. Midline: _____

12. Other: _____

_____

_____

Est. Tx Time: _____

Tx Plan: _____

_____

Extractions: _____

Appliances: _____

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