J. Thomas Hedrick, D.D.S., M.S.D.
Aleco E. Tujios, D.D.S, M.S.
Jeffrey G. Johnson, D.D.S, M.S.

WOODHILL DENTAL SPECIALTIES - SPECIALISTS IN PEDIATRIC DENTISTRY & ORTHODONTICS
8355 WALNUT HILL LANE, SUITE 100, DALLAS, TEXAS 75231 PHONE: 214-691-1172 FAX: 214-239-8597

PERSONAL HISTORY

FULL LEGAL NAME	PREFERRED NAME		
BIRTHDATE	AGE	SEX	
STREET	CITY	STATE	ZIP
MAIN CONTACT TELEPHONE NUMBER	MAIN CONTACT EMAIL ADDRESS		
FULL NAME OF RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT		
CELL PHONE NUMBER OF RESPONSIBLE PARTY	OCCUPATION OF RESPONSIBLE PARTY		
MARITAL STATUS (PLEASE CHECK ONE): ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED			
ADDRESS IF DIFFERENT FROM ABOVE			
SPOUSE'S / SIGNIFICANT-OTHER'S FULL NAME	RELATIONSHIP TO PATIENT		
CELL PHONE NUMBER	OCCUPATION		
ADDRESS IF DIFFERENT FROM ABOVE			
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE		

SOCIAL HISTORY

HOW, OR FROM WHOM DID YOU LEARN ABOUT OUR PRACTICE?
HAVE WE SEEN YOU OR ANYONE ELSE IN YOUR FAMILY IN OUR OFFICE BEFORE? IF SO, PLEASE TELL US WHO.

DENTAL INSURANCE

NAME OF POLICYHOLDER (INSURED)	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NUMBER
EMPLOYER	EMPLOYER'S PHONE	
INSURANCE COMPANY'S NAME	INSURANCE COMPANY'S PHONE	
INSURANCE COMPANY'S ADDRESS	GROUP NUMBER	MEMBER ID NUMBER

MEDICAL HISTORY

PHYSICIAN'S NAME	DATE OF LAST VISIT
ADDRESS	PHONE

PLEASE CHECK YES OR NO (IF YES, PLEASE FILL IN DETAILS)

☐ YES	☐ NO	Is the patient taking any medication?
☐ YES	☐ NO	Is the patient allergic to any medication?
☐ YES	☐ NO	History of a major illness?
☐ YES	☐ NO	Has the patient had any operations?
☐ YES	☐ NO	Ever been involved in a serious accident
☐ YES	☐ NO	Seen a physician in the last 12 months? Why?
☐ YES	☐ NO	Female patients only: Is the patient pregnant?

CHECK ANY MEDICAL CONDITIONS BELOW THAT THE PATIENT HAS HAD OR CURRENTLY HAS

☐ Abnormal bleeding/Hemophilia	☐ Diabetes	☐ Hepatitis/Liver Problems	☐ Pneumonia
☐ Anemia	☐ Dizziness	☐ Herpes	☐ Prolonged Bleeding
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Radiation/Chemotherapy
☐ Asthma or Hayfever	☐ Gastrointestinal Disorders	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Bone Disorders	☐ Heart Problems	☐ Kidney Problems	☐ Tuberculosis
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Nervous Disorders	☐ Tumor or Cancer
ARE THERE ANY MEDICAL CONDITIONS WE HAVE NOT DISCUSSED THAT YOU FEEL WE SHOULD BE AWARE OF?			

DENTAL HISTORY

GENERAL DENTIST'S FIRST /LAST NAME	DATE OF LAST VISIT
ADDRESS	PHONE
WHAT CONCERNS YOU MOST ABOUT YOUR TEETH?	

☐ YES	☐ NO	Is the patient presently in any dental pain?
☐ YES	☐ NO	Ever experienced any unfavorable reaction to dentistry?
☐ YES	☐ NO	Has the patient ever lost or chipped any teeth?
☐ YES	☐ NO	Have there been any injuries to face, mouth or teeth?
☐ YES	☐ NO	Is any part of your mouth sensitive to temperature? Where?
☐ YES	☐ NO	Is any part of your mouth sensitive to pressure? Where?
☐ YES	☐ NO	Do gums bleed when brushing?
☐ YES	☐ NO	Any type of thumb or tongue habit?
☐ YES	☐ NO	Is the patient a mouth-breather?
☐ YES	☐ NO	Has the patient ever seen an orthodontist? If yes, who and when?
☐ YES	☐ NO	Has anyone in the family received orthodontic treatment?
		How did they feel about the result?
☐ YES	☐ NO	Do teeth or jaws ever feel uncomfortable first thing in the morning?
☐ YES	☐ NO	Experience jaw clicking or popping?
☐ YES	☐ NO	Aware of clenching or grinding teeth during the day?
☐ YES	☐ NO	Experience “tension” headaches?
☐ YES	☐ NO	Has the patient ever experienced chronic ringing in the ears?
☐ YES	☐ NO	Does the patient need extra help with instructions?

☐ YES	☐ NO	Is the patient sensitive or self-conscious about his/her teeth?
What is the patient's attitude toward receiving orthodontic treatment?		

BENEFITS

Benefits of Orthodontics. Aesthetica, Health and Function. Orthodontics is a service that provides and improvement in the appearance of the teeth. In the general function of the teeth, and in general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph.

I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. ____ to perform a complete orthodontic evaluation.

Signature: ____ Date: ___________________