Springwood Professional Center
11329 Springfield Pike
Cincinnati, Ohio 45246
(513) 772-1671

BRYAN R. WIRTZ
D.D.S., M.S.
SPECIALIST IN ORTHODONTICS
www.bryanwirtzorthodontics.com

Liberty Professional Center
7100 Sennet Place, Suite F
West Chester, Ohio 45069
(513) 755-9100

We would like to welcome you to our office. In an effort to provide the best service possible, we ask that you fill out this form as completely as possible. Thank you for your cooperation.

Today's Date _____

Patient Information - Adult

Patient's Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ ❒ Male ❒ Female

Home Address _____ City _____ State _____ Zip _____

Social Security Number _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ How Long? _____

Emergency Contact Name _____ Phone _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? ❒ Yes ❒ No If Yes, name _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have you visited an orthodontist before? ❒ Yes ❒ No If Yes, for what reason? _____

Is there anything you would like to discuss with the doctor in private? ❒ Yes ❒ No

Dental Insurance Information

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Domestic Partner

Primary Dental

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____

Group or Plan _____ Insurance ID # _____

Insured's Name _____ Insured's Birth Date _____

Relationship to Patient _____ Insured's Social Security Number _____

Insured's Employer _____ Employer's Address _____

Secondary Dental

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____

Group or Plan _____ Insurance ID # _____

Insured's Name _____ Insured's Birth Date _____

Relationship to Patient _____ Insured's Social Security Number _____

Insured's Employer _____ Employer's Address _____

Please complete both sides.

Dental and Medical History

Are you currently under the care of a physician? ❒ Yes ❒ No If Yes, for what reason? _____

Physician _____ Phone _____

History of major illness? ❒ Yes ❒ No If Yes, please describe _____

Currently taking any medications? ❒ Yes ❒ No If Yes, please list _____Amount/Dose _____

Are you required to take antibiotics before dental treatment? ❒ Yes ❒ No If Yes, explain _____

Have you ever had a serious / difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Your current dental health is: ❒ Good ❒ Fair ❒ Poor Do you have any missing or extra permanent teeth? ❒ Yes ❒ No

Do you like your smile? ❒ Yes ❒ No Do your gums bleed? ❒ Yes ❒ No

Have you ever had an injury to your: ❒ Mouth ❒ Teeth ❒ Chin

Do you have any speech problems? ❒ Yes ❒ No If Yes, please describe _____

Do you generally breathe through your mouth? Awake? ❒ Yes ❒ No Asleep? ❒ Yes ❒ No

Check (▮) if you ever had any of the following diseases or medical problems:

- ❒ Anemia / Radiation Treatment
- ❒ Artificial Bones / Joints
- ❒ Artificial Valves
- ❒ Asthma / Arthritis
- ❒ Blood Transfusion
- ❒ Cancer / Chemotherapy
- ❒ Congenital Heart Defect
- ❒ Diabetes / Tuberculosis (TB)
- ❒ Difficulty Breathing
- ❒ Drug / Alcohol Abuse
- ❒ Emphysema / Glaucoma
- ❒ Epilepsy/Seizures/Fainting Spells
- ❒ Fever Blisters / Herpes
- ❒ Heart Attack / Stroke
- ❒ Heart Murmur
- ❒ Heart Surgery / Pacemaker
- ❒ Hemophilia / Abnormal Bleeding
- ❒ Hepatitis
- ❒ High / Low Blood Pressure
- ❒ HIV positive / AIDS
- ❒ Hospitalized for any reason
- ❒ Kidney / Liver Problems
- ❒ Mitral Valve Prolapse
- ❒ Psychiatric Problems
- ❒ Rheumatic / Scarlet Fever
- ❒ Severe / Frequent Headaches
- ❒ Shingles
- ❒ Sinus Problems
- ❒ Ulcers / Colitis
- ❒ Venereal Disease

Check (▮) if you are allergic to any of the following:

- ❒ Aspirin
- ❒ Any Metal / Plastic
- ❒ Latex
- ❒ Codeine
- ❒ Dental Anesthetics
- ❒ Erythromycin
- ❒ Penicillin
- ❒ Tetracycline

❒ Other, Please list any other drugs that you are allergic to:_____

_____

_____

For Women:

Are you taking birth control pills? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No Week #_____

Are you nursing? ❒ Yes ❒ No

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials_____ Date_____

Doctor's Comments:

_____

_____

_____

_____