WOOLAVER
CLEARSMILES
invisalign | orthodontics

4425 E. Agave Rd., Ste. 126
Phoenix, AZ 85044
(Ray Rd & 44th St)
p480.240.9393
f480.240.9394

clearsmilesaz.com

PATIENT/FAMILY INFORMATION

Name _____ *Male / Female* Birthdate _____ Age _____
First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone _____

Mother _____ Occupation _____ Are the Patient's Parents Married?

Father _____ Occupation _____ Y N

Sibling _____ Age _____

_____ Age _____ What School does the patient go to? _____ Grade _____

_____ Age _____

We confirm appointments via email and text message for your convenience (no text charges apply)

Email _____ Cell _____ Cell Carrier _____

Has patient ever had an orthodontic exam before? *Yes No* Dr's Name _____ How long ago? _____

Who may we thank for referring you to our office? _____

Or, how did you hear about us? Insurance Internet Newspaper Magazine Direct Mail Trade Show

Community Event Yellow Pages School Other _____

RESPONSIBLE PARTY INFORMATION

PRIMARY RESPONSIBLE PARTY

Name _____
First MI Last

Same Address As Above ☐

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

SECONDARY INSURED (IF APPLICABLE)

Name _____
First MI Last

Same Address As Above ☐

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Required only if you would like us to verify insurance to provide accurate estimate, or if we are extending financing

Birthdate _____

SS# _____

Birthdate _____

SS# _____

INSURANCE INFORMATION

Employer Name _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____

ID # _____

Group # _____

INSURANCE INFORMATION

Employer Name _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____

ID # _____

Group # _____

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PATIENT NAME _____

MEDICAL INFORMATION

YES	NO		YES	NO		YES	NO		
___	___	Latex Allergy	___	___	Cancer or Tumors	___	___	Liver Disease	**List any medications patient is taking** _____
___	___	Other Allergies:	___	___	Diabetes	___	___	Intestinal Disease	_____
		_____	___	___	Pregnant	___	___	Asthma	_____
		_____	___	___	Heart Valve Problems	___	___	Autism	
___	___	Heart Disease	___	___	Epilepsy	___	___	Bone Disease	**List any concerns not mentioned that we should know about**
___	___	Respiratory Disease	___	___	HIV/AIDS	___	___	Prolonged Bleeding	_____
___	___	Blood Disease	___	___	Hepatitis	___	___	Tuberculosis	_____
___	___	Thyroid Disorder	___	___	Kidney Disorder	___	___	Bisphosphonates	_____
___	___	ADHD	___	___	Artificial Joints			(for osteoporosis)	_____
___	___	Stroke	___	___	Radiation/Chemotherapy	___	___	High/Low Blood Pressure	_____
___	___	Fainting/Dizziness	___	___	Nervous Condition	___	___	Does Patient Smoke	_____

DENTAL INFORMATION

YES	NO		YES	NO	
___	___	Has Patient Seen a General Dentist in the Last Year	___	___	Thumb Sucking
___	___	Any Discomfort or Noises in the Jaw Joints	___	___	Grind Teeth
___	___	Have the Mouth, Face, or Teeth Been Injured in Accident	___	___	Speech Problem/Therapy
___	___	Are You Aware of Any "Gum" Problems	___	___	Tonsils/Adenoids Removed
___	___	Have Any Family Members Had Orthodontic Treatment			

Dentist Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

What would you like to improve about your (your child's) teeth and smile? _____

_____

Do you have any specific questions for Dr. Woolaver? _____

The information given on this form is accurate and I understand that I am obligated to inform Dr. Woolaver immediately of any changes.

Signature of Patient or Parent/Guardian if Patient is a Minor _____ Date _____

Reviewed By Dr. Woolaver _____ Date _____

_____

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