



Dr. Wayne N Wyatt Dr. C Michael Flint

Date of Exam \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

**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 (for appointment reminders):**  
\_\_\_\_\_

**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 / Bleeding disorder
Hepatitis	Severe / Frequent Headaches

Any other medical problems / diseases? \_\_\_\_\_

**How did you hear about our office?**

Friend \_\_\_\_\_

Dentist \_\_\_\_\_

Internet \_\_\_\_\_

Insurance \_\_\_\_\_

**Current Dentist** \_\_\_\_\_

**What are your main concerns regarding your teeth?**  
\_\_\_\_\_

**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: _____	7. Crossbite: Ant Post ( Rt Lt Bilat ) _____	
2. Class: I II III E/E Div: _____		
3. Overbite: Deep Imping Open _____ mm	8. Impacted teeth: _____	
4. Overjet: Norm Mod. Severe _____ mm	9. TMJ: _____	Est. Tx Time: _____
Underbite	10. Habits: _____	Tx Plan: _____
5. Crowding: _____	11. Midline: _____	
Upper: Minor Moderate Severe	12. Other: _____	Extractions: _____
Lower: Minor Moderate Severe		Appliances: _____
6. Spacing: _____		Fee: _____
REEX: _____		
		Chart #: _____
		SC#: _____



**WYATT**  **FLINT**  
ORTHODONTICS

**WYATT & FLINT ORTHODONTICS**  
**WAYNE N WYATT, DDS, MS, PC**  
**C MICHAEL FLINT, DDS**  
**Tulsa / Claremore / Sand Springs**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

I consent for the office of Wyatt & Flint Orthodontics, to share my personal and financial information with the following:  
(family, friends, etc.)

Name / Relationship / Phone

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



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**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 & Flint 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.

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Please Print Name

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Signature of Patient / Parent / Guardian

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Date

Expiration -- 3 Years from Initial Signature: \_\_\_\_\_  
Date

Expiration -- Change in Insurance Coverage

Expiration -- Patient reaches the age of 18: \_\_\_\_\_  
Date of Age 18