ADULT PATIENT INFORMATION

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Olmsted ORTHODONTICS

Members American Association of Orthodontists

Today's Date:

Patient Name: First	Last	Nickname	Gender	Age:
Address:	City:	State:	Zip:	
Reason for visit:	Who is Your Dentist?	How many years?	Patient Birthdate	
Preferred Orthodontic Appointment Times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime	☐ M ☐ Tu ☐ W ☐ Th ☐ Fri		Patient Home Phone	
How did you hear about us? Select	Whom should we thank for referring you to our office?		Patient Cell Phone	
Has anyone else in your family been treated by a different orthodontist?	Yes ☐	No ☐	If yes, who?	Patient Work Phone
Has anyone else in your family been treated in our office?	Yes ☐	No ☐	If yes, who?	
Your Interest, Hobbies, Sports:			Patient Email Address	

Marital Status: Married: ☐ Single: ☐ Separated: ☐ Divorced : ☐ Widowed : ☐

If Married, Spouse Name: If Spouse Address is different from yours please fill in below:	Spouse Birthdate	Spouse Work Phone	Spouse Cell Phone:
Address:	City	State:	Zip:

Children	Age	Birthdate	Children	Age	Birthdate

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for this account?	☐ Self	☐ Spouse	Someone Else-- If "Someone Else" will be responsible for this account other than self or spouse, please fill out form below:
Name:			Select Relationship to Pat
Cell Phone:	Home Phone:	Work Phone:	Email:
Address:	City	State:	Zip:

EMPLOYMENT INFORMATION

Your Employer:		Spouse's Employer:	
Business Address:		Business Address:	
Business Phone:		Business Phone:	
Your job Title:	Length of Employment?	Spouse's Job Title:	Length of Employment?

NEW PATIENT INSURANCE INFORMATION

Do you have insurance coverage which includes orthodontic treatment for members of your family?	Yes ☐	No ☐	If "yes" please fill form below:

Policy#1	Policy #2
Policy Holder:	Policy Holder:
Insurance Company:	Insurance Company:
Insured Social Security #:	Insured Social Security #:
Insured Member ID:	Insured Member ID:
Insured's Group #:	Insured's Group #:
Insured's Date of Birth:	Insured's Date of Birth:
Insurance Phone #:	Insurance Phone #:
Insurance Address:	Insurance Address:

Emergency Contact: Name: _____ Phone: _____ Relation to you Select

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

MEDICAL HISTORY

Name of Physician: *Physician Phone #*

Have you ever had any of the following? Please check those that apply:

☐ *AIDS*	☐ *Endocrine Problems*	☐ *Kidney Disease*	☐ *Sinus Problems*
☐ *Allergies (List below)*	☐ *Prolonged Bleeding*	☐ *Liver Disease*	☐ *Stomach Problems*
☐ *Anemia*	☐ *Fainting*	☐ *Emotional Problems*	☐ *Stroke*
☐ *Artificial Joints*	☐ *Glaucoma*	☐ *Nervous Disorders*	☐ *Tonsils Removed*
☐ *Asthma*	☐ *Hay Fever*	☐ *Pacemaker*	☐ *Tuberculosis*
☐ *Blood Disease*	☐ *Head Injuries*	☐ *Pregnant (due date)*_____	☐ *Tumors*
☐ *Arthritis/Joint Problems*	☐ *Heart Disease*	☐ *Radiation Treatment*	☐ *Ulcers*
☐ *Cancer (type)* _____	☐ *Heart Murmur*	☐ *Respiratory Problems*	☐ *Venereal Disease*
☐ *Diabetes*	☐ *Hepatitis*	☐ *Rheumatic Fever*	☐ *Nickel Allergy*
☐ *Dizziness*	☐ *High Blood Pressure*	☐ *Rheumatism*	☐ *Latex Allergy*
☐ *Epilepsy*	☐ *Jaundice*		

List any allergies: _____

Current Medications:

Have you been admitted to a hospital or needed emergency care during the past two years? *Yes* ☐ *No* ☐ *If yes please explain:*

Are you currently being treated for any medical condition? *Yes* ☐ *No* ☐ *If "Yes", please explain*

DENTAL HISTORY

Have you ever had any of the following? Please check those that apply:

☐ *Injuries to face, mouth, teeth*	☐ *Clenching or grinding teeth*
☐ *Thumb, finger or lip sucking habits*	☐ *Chronically sore or bleeding gums*
☐ *Speech problems*	☐ *PeriodonticsGum treatment or surgery (date)* _____
☐ *Mouth breathing when asleep or awake*	☐ *Reaction to dental medications (type)* _____
☐ *Missing or extra permanent teeth*	☐ *Difficulty chewing or swallowing food*
☐ *Teeth removed by extraction (date)*_____	☐ *Frequent headaches (number per week)* _____
☐ *Endodontics (Root canal) (date)*_____	☐ *Trouble associated with dental treatment*
☐ *Tongue thrust*	☐ *Muscle tenderness or stiffness in the jaw or neck*
☐ *Ringing sounds in the ear or dizziness*	☐ *TMJ - Pain, popping, locking on opening and closing jaw*
☐ *Experience a sudden increase in height*	

Do you visit your dentist regularly? *Yes* ☐ *No* ☐ *Date of last visit:*

Have you previously consulted another orthodontist? *Yes* ☐ *No* ☐ *Orthodontist Name/s:*

Have you ever had any complications following dental treatment? *Yes* ☐ *No* ☐ *If "Yes" Please explain below:*

A member of the family or close relative with similar arrangement of the teeth or appearance of jaws? *Yes* ☐ *No* ☐

Concerns about appearance of jaws: *Yes* ☐ *No* ☐ *Do you smoke or use tobacco products?* *Yes* ☐ *No* ☐

Want to discuss Invisalign as an option? *Yes* ☐ *No* ☐ *Are you reluctant to wear braces?* *Yes* ☐ *No* ☐

CONSENT FOR SERVICES

1. I hereby authorize Dr. Matthew Olmsted or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Olmsted to make a thorough diagnosis.

2. Upon such diagnosis, I authorize Dr. Olmsted, associates, and clinical technicians to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

4. I hereby give Dr. Matthew Olmsted the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Signature of patient, parent, or guardian *Date* *Relationship to Patient*