# LEBER ORTHO

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# WELCOME

**DATE** _____

## ADULT PATIENT INFORMATION

Patient's Name _____ Marital Status_____

Prefer to be called_____Age _____Gender: F M Birth date_____/_____/_____

Home Phone_____Work Phone_____

Cell Phone_____E-mail_____

Home Address_____ City, State _____ Zip_____

Own [ ] Rent [ ] Previous Address (if less that 3 years) _____

Patient's hobbies/sports/instruments_____

Names of other members in family previously treated by us _____

General Dentist _____ Date of last cleaning (Mo/Year) _____

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

If transferring, previous DDS _____

## PATIENT EMPLOYMENT INFORMATION

Employer_____ Occupation_____ No. Years Employed _____

Dental insurance through current employer ____ Y ____N **Expected Ortho Benefit $**_____

Dental Insurance Company_____ Group #_____

Address _____ Phone _____

Insured's Birth date _____/_____/_____ ID # _____ Social Security #_____

## SPOUSE'S EMPLOYMENT INFORMATION

Name _____ Marital Status_____

Home Address (If different)_____City, State_____Zip_____

Own [ ] Rent [ ] Previous Address (if less that 3 years) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer_____ Occupation_____ No. Years Employed _____

Dental insurance through current employer ____ Y ____N **Expected Ortho Benefit $**_____

Dental Insurance Company_____ Group #_____

Address _____ Phone _____

Insured's Birth date _____/_____/_____ ID # _____ Social Security # _____

## EMERGENCY CONTACT

Name of nearest **relative not living with you** (Relationship) _____

Address _____ Home Phone_____

City, State _____ Zip_____ Alternate Phone_____

PLEASE COMPLETE REVERSE SIDE

## HEALTH HISTORY

**Please check box if patient has (or had) any of the following:**

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

**ANY ALLERGIES TO:** ❑ Latex ❑ Metal/Nickel ❑ Plastic ❑ Peanuts ❑ Dental Anesthetics
❑ Aspirin ❑ Erythromycin ❑ Penicillin ❑ Tetracycline ❑ Codeine

List any other drugs you are allergic to:_____

**Physician** _____**Phone #:** (  )_____ **Last Visit** _____

Your current general health is ❑ Good ❑ Fair ❑ Poor

Routinely need pre-medication before dental procedures **YES / NO**

Are you under physician's care? **YES / NO**

If so, for what reason _____

Is patient taking prescription medications? **YES / NO**

If so, please list _____

List any additional health related issues _____

## DENTAL HISTORY

| | YES | NO |
|---|---|---|
| Have you ever been evaluated for orthodontic treatment? | ❑ | ❑ |
| Have you ever had a serious/difficult problem associated with any previous dental work? | ❑ | ❑ |
| Do you now or have you ever experience pain/discomfort in your jaw joint (TMJ/TMD)? | ❑ | ❑ |
| Do you like your smile? | ❑ | ❑ |
| Do your gums ever bleed? | ❑ | ❑ |
| Do you have any missing or extra permanent teeth? | ❑ | ❑ |
| Do you generally breath through your mouth when awake? | ❑ | ❑ |
| Do you generally breath through your mouth when asleep? | ❑ | ❑ |

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Have you ever had an injury to your ❑ Mouth ❑ Teeth ❑ Chin? _____

Do you have any speech problems?_____

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

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services with my informed consent that I may need during diagnosis and treatment.

**Signature** _____ **Date**_____