Leber Orthodontics

Larry Leber DDS, MS • Eric Leber DDS, MS

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 _____

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**_____