LEBER ORTHO

Larry Leber DDS, MS • Eric Leber, DDS, MS

WELCOME

DATE _____

PATIENT INFORMATION

Patient's Name _____

Prefer to be called _____ Age _____ Gender: F M

Birth date_____/ _____ /_____ Home Phone _____ School _____ Grade_____

Home Address_____ City, State _____ Zip_____

Patient's hobbies/sports/instruments_____

Names and ages of other children in family _____

Names of other children in family previously treated by us_____

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

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

Who is accompanying you child today? Name _____ Relation _____

If transferring, previous DDS _____

FATHER'S INFORMATION

Name _____ Legal Custody ___ Yes ___ No

Check if Applicable ❑ Stepfather ❑ Guardian Marital Status _____

Home Address_____ City, State _____ Zip_____

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

Home Phone_____Work Phone_____

Cell Phone_____E-mail_____

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 # _____

MOTHER'S INFORMATION

Name _____ Legal Custody ___ Yes ___ No

Check if Applicable ❑ Stepmother ❑ Guardian Marital Status _____

Home Address (If different)_____ City, State _____ Zip_____

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

Home Phone_____Work Phone_____

Cell Phone_____E-mail_____

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:

Allergies	❑	Endocrine/Thyroid problem	❑	Liver/Kidney Problem	❑
Anemia	❑	Fainting	❑	Nervous/Hyperactive	❑
Asthma	❑	Fever Blisters/Herpes	❑	Prolonged Bleeding	❑
Blood Transfusion	❑	Frequent Headaches	❑	Rheumatic Fever	❑
Bone Disorder/Osteoporosis	❑	Glaucoma	❑	Tobacco Use	❑
Cancer	❑	Handicaps/Disabilities	❑	Tuberculosis	❑
Convulsions	❑	Hearing Problems	❑	Hepatitis	❑
Emotional Problems	❑	Heart Problems	❑	Removal of Tonsils/Adenoids	❑
Artificial Bones/Joints/Valves	❑	HIV (tested positive)/Aids	❑		

ANY ALLERGIES TO: ❑ Latex ❑ Metal/Nickel ❑ Plastic ❑ Penicillin ❑ Peanuts

Child's Physician_____ **Phone #: ( )**_____

Routinely need pre-medication before dental procedures **YES / NO**
Is patient under physician's care? **YES / NO**
If so, for what reason _____
Is patient taking prescription medications? **YES / NO**
If so, please list _____
For children and adolescence only:
Has puberty been reached? **YES / NO**
If so, has it been within the last two years? **YES / NO**
List any additional health related issues _____

DENTAL HISTORY

	YES	NO	
Any congenitally missing teeth?	❑	❑	
Any extra teeth?	❑	❑	
Have any primary/permanent teeth been extracted?	❑	❑	
Has patient ever sucked thumb or finger?	❑	❑	(How old when stopped?_____)
Clicking or pain when opening jaws? TMJ Problems?	❑	❑	
Any night-time clenching or grinding habit?	❑	❑	
Any speech problems?	❑	❑	
Frequent mouth breathing? (awake/sleeping)	❑	❑	
Has any sibling had orthodontic treatment?	❑	❑	
Has either parent had orthodontic treatment?	❑	❑	
Surgery to repair cleft lip and/or cleft palate?	❑	❑	
Has patient ever seen an Orthodontist?	❑	❑	
Has patient been ridiculed about appearance of teeth?	❑	❑	

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

_____

_____

I confirm the information I have given is correct and I authorize the dental staff to perform the necessary dental services my child may need.

Signature (parent guardian if minor) _____ **Date**_____