Olm Orthodontics

548 Red Bird Circle De Pere WI 54115
920-964-0144

PATIENT INFORMATION

PATIENT NAME _____ DATE _____
LAST FIRST M.I.
DATE OF BIRTH _____ AGE _____ SEX _____ PHONE # _____
ADDRESS _____ REFERRED BY _____
CITY _____ STATE _____ ZIP _____ DENTIST _____
FAMILY MEMBERS PREVIOUSLY SEEN _____ ORAL SURGEON _____
_____ DOCTOR _____
PERSON RESPONSIBLE FOR ACCOUNT _____ EMERGENCY CONTACT _____
ADDRESS (IF DIFFERENT) _____ EMERGENCY PHONE # _____
CITY _____ STATE _____ ZIP _____

PARENT INFORMATION (IF PATIENT IS UNDER THE AGE OF 18)

FATHER'S NAME _____ MOTHER'S NAME _____
ADDRESS _____ ADDRESS _____
CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____
PHONE # _____ PHONE # _____
CELL PHONE # _____ CELL PHONE # _____
WORK PHONE # _____ WORK PHONE # _____
SOCIAL SECURITY # _____ SOCIAL SECURITY # _____
DATE OF BIRTH _____ DATE OF BIRTH _____

PRIMARY DENTAL INSURANCE COMPANY

SUBSCRIBER NAME _____
ADDRESS (IF DIFFERENT) _____
CITY _____ STATE _____ ZIP _____
PHONE # _____
RELATIONSHIP TO PATIENT _____
EMPLOYED BY _____
EMPLOYER ADDRESS _____
CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
COMPANY PHONE # _____
ID # _____
GROUP # _____

SECONDARY DENTAL INSURANCE COMPANY

SUBSCRIBER NAME _____
ADDRESS (IF DIFFERENT) _____
CITY _____ STATE _____ ZIP _____
PHONE # _____
RELATIONSHIP TO PATIENT _____
EMPLOYED BY _____
EMPLOYER ADDRESS _____
CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
COMPANY PHONE # _____
ID # _____
GROUP # _____

For those patients who forego our 5% courtesy discount for payment in full, Olm Orthodontics provides in-house financing subject to a credit analysis. Please sign for authorization _____

I hereby authorize release of any information relating to claims for orthodontic services to my insurance company.

_____ _____
SIGNATURE DATE

I hereby authorize payment directly to Olm Orthodontics, S.C. of the insurance benefits otherwise payable to me.

_____ _____
SIGNATURE DATE

PATIENT MEDICAL HISTORY

CIRCLE ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

DIABETES	TUBERCULOSIS	KIDNEY PROBLEMS
EPILEPSY	ASTHMA	BONE DISORDER
ANEMIA	LIVER PROBLEMS	NERVOUS DISORDER
PROLONGED BLEEDING	HEPATITIS	TONSILLITIS
HEART TROUBLE	BLOOD TRANSFUSION	FAINTING/DIZZINESS
HEART MURMUR	AIDS/HIV POSITIVE	SINUS PROBLEMS
MITRAL VALVE PROLAPSE	ENDOCRINE PROBLEMS	JAW PAIN
RHEUMATIC FEVER	LATEX ALLERGY	SURGICAL IMPLANT
HIGH BLOOD PRESSURE	NICKEL ALLERGY	OTHER

LIST ANY HISTORY OF MAJOR ILLNESS

_____

_____

DOES THE PATIENT HAVE A TENDENCY TO? COLDS SORE THROATS EAR INFECTIONS

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES NO WHAT AGE? _____

PLEASE LIST: ALLERGIES OR DRUG SENSITIVITIES DRUGS OR MEDICATIONS BEING TAKEN

_____ _____

_____ _____

PATIENT DENTAL HISTORY

CIRCLE ANY OF THE FOLLOWING WHICH THE PATIENT HAS EXPERIENCED

BAD BREATH	GRINDING OF TEETH	CLENCHING OF TEETH
BLEEDING GUMS	PERIODONTAL DISEASE	TOOTH SENSITIVITY
JAW CLICKING OR POPPING	SORES OR GROWTHS IN MOUTH	EXTRA TEETH
MISSING TEETH	DELAYED TOOTH ERUPTION	OTHER _____

CIRCLE ANY OF THE FOLLOWING HABITS WHICH THE PATIENT MAY HAVE

FINGER/THUMB SUCKING	LIP BITING/SUCKING	TONGUE THRUST
MOUTH BREATHING	NAIL BITING	OTHER _____

CIRCLE ANY OF THE FOLLOWING WHICH ARE CONCERNS OF THE PATIENT

CROWDING	GUMMY SMILE	CLICKING JAW JOINT
SPACES	GUM DISEASE/RECESSION	IRREGULARLY SHAPED TEETH
OVERBITE	MISSING TEETH	PROTRUSION OF TEETH
"BUCK TEETH"	JAW DYSFUNCTION	HEADACHES/FACIAL PAIN
RECEDED JAW	SMALL MOUTH	NECK PAIN
PROMINENT JAW	IRREGULAR FACIAL STRUCTURE	OTHER _____

HOW OFTEN DO YOU HAVE A DENTAL CHECKUP? ONCE A YEAR TWICE A YEAR ONLY IF URGENT NEVER

HAVE YOU HAD A PREVIOUS ORTHODONTIC EXAM OR TREATMENT? YES NO

IS THE PATIENT INTERESTED IN ORTHODONTIC TREATMENT? YES NO

ARE YOU AWARE OF ANY ORTHODONTIC PROBLEMS? YES NO

HAS THE PATIENT HAD ANY INJURIES TO THE TEETH, MOUTH OR JAWS? YES NO

IF SO, PLEASE EXPLAIN _____

_____

_____ _____

SIGNATURE RELATIONSHIP TO PATIENT