



OLM ORTHODONTICS

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Specialist in Orthodontics

PATIENT INFORMATION

Patient Name _____
LAST FIRST M.I.
 Date of Birth _____ Age _____ Sex _____
 Address _____
 City _____ State _____ Zip _____
 Family Members Previously Seen _____

 Person Responsible for Account _____
 Address (IF DIFFERENT) _____
 City _____ State _____ Zip _____

Date _____
 Phone # _____
 Referred by _____
 Dentist _____
 Oral Surgeon _____
 Doctor _____
 Emergency Contact _____
 Emergency Phone # _____

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

Parent 1 Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone # _____
 Cell Phone # _____
 Work Phone # _____
 Social Security # _____
 Date of Birth _____

Parent 2 Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone # _____
 Cell Phone # _____
 Work Phone # _____
 Social Security # _____
 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 _____
 Name 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 # _____

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

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

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 jaw? YES NO
If so, please explain _____

SIGNATURE RELATIONSHIP TO PATIENT

