MAPLEWOOD VILLAGE
3628 North 90th Street
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Phone: (402) 571-1108
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www.drolsonortho.com

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17465 Manderson Street
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Phone: (402) 571-1108
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NEW PATIENT INFORMATION FOR ADULT PATIENTS

Date: ________________

Patient's Last Name: _____________________________ First Name: ________________________ Middle Initial: ________

Birthdate:______________________ Age: __________ Sex: M F Prefers to be called: __________________________

S.S.N.:______________________________________ Home Phone: ____

Address: ____ Zip: ______________________

Patient's Employer: ____ Work or Cell Phone: ___________________________

Patient's Email: ____

Other family members treated here: ____

Whom may we thank for referring you? ____

What is your main concern today? ____

Marital status: Single Married Divorced

Spouse's Name: ____

Spouse's Employer: ____

Spouse's phone: ____

Do we have permission to run a credit check? (please initial) YES _______ NO _______

Orthodontic Insurance: YES NO

Name of Insured: ____ Date of Birth:______________________________

Insurance Co. Name: ____

I.D. Number: ____Group Number:_______________________________

Insurance Co. Phone No.: _________________________________ Insured Person S.S.N.: _____________________________

Insurance Address: ____

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CONFIDENTIAL MEDICAL AND DENTAL HISTORY FOR ADULT PATIENTS

Patient's Name____ Date: ____________________

MEDICAL HISTORY

Name of Physician: ____

Are you currently under physician's care? YES NO If yes, for: ______________________________________

Are you taking any medications? YES NO If yes, please list: ____

Do you have any allergies? YES NO If yes, please list: ____

Do you use tobacco? YES NO If yes, please explain ____

Have tonsils and/or adenoids been removed? YES NO If yes, what age? ______________________________

Are you frequently bothered with nasal, sinus infections, or sore throats? YES NO

Have you ever been hospitalized? YES NO If yes, for: ______________________________ Date:___________

Any illnesses? If yes, please explain: ____

Females: Are you pregnant? YES NO

DENTAL HISTORY

Name of Dentist: ____Date of last exam: ______________

Have you ever had orthodontic treatment before: YES NO

If so, by whom: ____ Date of treatment: ____________________

Does anyone in your family have a similar tooth or jaw problem? YES NO

If yes, please explain: ____

Have you seen another orthodontist for this problem? YES NO

Please answer yes or no to the following:

Do you grind your teeth at night?	YES	NO
Are you concerned with any worn down or broken teeth?	YES	NO
Have you ever been diagnosed with any periodontal (gum or bone) disease?	YES	NO
Have you ever had any permanent or "extra" supernumerary teeth removed?	YES	NO
Do you have any joint noises, pain, or discomfort?	YES	NO
Have you ever fractured your jaw bone or had a previous jaw surgery?	YES	NO

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Patient's SIGNATURE and DATE:

____