OLSON ORTHODONTICS

MAPLEWOOD VILLAGE
3628 North 90th Street
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17465 Manderson Street
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NEW PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Birthdate:_____ Age: _____ Sex: M F Prefers to be called: _____

S.S.N.:_____ Home Phone: _____

Patient's Address: _____ Zip: _____

School Name: _____ Grade: _____ Musical Instruments Played: _____

Sports and/or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

Whom may we thank for referring you? _____

What is your main concern today? _____

Person Responsible: _____ E-mail: _____

Mother's Name: _____ Mother's S.S.N: _____

Mother's Employer: _____ Mother's work or cell phone: _____

Father's Name: _____ Father's S.S.N: _____

Father's Employer: _____ Father's work or cell phone: _____

Marital Status of Parents: Single Married Divorced

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 PATIENTS UNDER 18 YEARS OF AGE

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: _____

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: _____

DENTAL HISTORY

Name of Dentist: _____Date of last exam: _____

Have you ever had orthodontic treatment before: YES NO

Is 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:

Has the patient ever had a finger or thumb sucking habit?	YES	NO
Does the patient grind his/her teeth at night?	YES	NO
Has the patient ever been diagnosed with any periodontal (gum or bone) disease?	YES	NO
Has the patient ever had trauma to the teeth, mouth, or face?	YES	NO
Has the patient ever had any primary teeth removed that were not loose?	YES	NO
Has the patient ever had any permanent or "extra" supernumerary teeth removed?	YES	NO
Does the patient have any joint noises, pain, or discomfort?	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.

Parent's SIGNATURE and DATE:

_____