MAPLEWOOD VILLAGE
3628 North 90th Street
Omaha, NE 68134
Phone: (402) 571-1108
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www.drolsonortho.com

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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: ____

Parent 1's Name: ____ S.S.N: ____

Parent 1's Employer: ___________________________________ work or cell phone: ___________________________

Parent 2's Name: ____ S.S.N: ____

Parent 2's address if different: ____

Parent 2's Employer: ___________________________________ 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

Person who carries insurance: ____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: ____

Females: Are you pregnant? YES NO

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:

____