Olson Orthodontics
Smiles for the whole family

PATIENT INFORMATION

Last Name	First Name	Nickname	S.S. Number	Sex	Date of Birth	Age

Address	City	State	Zip	Home Phone
				Cell Phone
School (If a Student) / Grade	single ☐ married ☐ sep ☐ divorced ☐ widow(er) ☐	Employed By/Occupation		Business Phone
Referred By	Name of General Dentist			Date of Last Visit

E-Mail Address: Add to Mailing List ☐

PARENT INFORMATION (please complete if patient is a minor)

Father's Name	single ☐ married ☐ separated ☐ divorced ☐ widower ☐	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation			Cell Phone / Business Phone
Mother's Name	single ☐ married ☐ separated ☐ divorced ☐ widow ☐	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation			Cell Phone / Business Phone

E-Mail Address: Add to Mailing List ☐

MEDICAL / DENTAL HISTORY

Is the patient in good health? _____ Yes ☐ No ☐
Does the patient have any history of major illness? _____ Yes ☐ No ☐
_____
Has the patient ever been under the care of a physician? _____ Yes ☐ No ☐
Please list: _____
Has there been any injuries to the face, mouth, or teeth? _____ Yes ☐ No ☐
_____
Has the patient ever sucked a thumb or fingers? At what age? _____ Yes ☐ No ☐
_____
Does the patient have any speech problems? _____ Yes ☐ No ☐
Is the patient a mouth breather? While awake? While asleep? _____ Yes ☐ No ☐
Have you been informed of any missing or extra permanent teeth? _____ Yes ☐ No ☐
Has either parent had orthodontic treatment? _____ Yes ☐ No ☐
Has an orthodontist been consulted previously? _____ Yes ☐ No ☐
Have tonsils and adenoids been removed? What age? _____ Yes ☐ No ☐
Height: _____ Weight: _____
Any history of TMJD (clicking, popping, pain in the jaw joint)? _____ Yes ☐ No ☐
Any history of clenching or grinding of the teeth? _____ Yes ☐ No ☐
Any history of periodontal treatment or gum disease? _____ Yes ☐ No ☐
Please classify your interest in orthodontic treatment: Very_____ Average _____
Low _____ objects _____
What do you hope to accomplish with orthodontic treatment? _____
_____
List any drugs or medications now being taken. Give reasons: _____
_____

Please check any of the following conditions or problems.

Asthma	☐	Fainting/dizziness	☐
Bone (fracture)	☐	Hearing	☐
Seizures	☐	Heart Trouble	☐
Diabetes	☐	Kidney Trouble	☐
Endocrine (Hormone)	☐	Liver Trouble	☐
Epilepsy	☐	Mumps	☐
Emotional Disorder	☐	Rheumatic Fever	☐
Excessive Bleeding	☐	Speech Disorder	☐
Eye	☐	Tuberculosis	☐
AIDS	☐	Hepatitis	☐
Herpes	☐	Rheumatic Fever	☐
Arthritis	☐	High Blood Pressure	☐
Blood Disorders	☐	Cancer	☐
Hay fever / Allergies	☐	Endocrine Problems	☐
Bone Disorders	☐	Cardiovascular Disease	☐
Heart Murmur	☐	Hip / Joint Replacement	☐
Birth Defects	☐	Pregnancy	☐
Thyroid Disorder	☐	Other:	

List any allergies or drug sensitivity: _____

Do you have orthodontic insurance? Yes ☐ No ☐ Name of Company?

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of the account.

_____
Signature (parent if patient is a minor)

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INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

Name	Relationship to Patient	Employed By/Occupation		Phone
Mailing Address		City State	Zip	Business Phone
Spouse's Name	Employed By/Occupation			Phone

DENTAL INSURANCE INFORMATION

Do you have dental insurance that covers orthodontics (child or adult - whichever is applicable)? Y N

Skip this section if no orthodontic coverage.

Name of Primary Insurance

Subscriber			
Relationship to Patient	Subscriber's Birth Date	Subscriber's SSN#	
Employer of Subscriber			
Employer's Address	City	State	Zip
Insurance Company Name	Group #		
Insurance ID # (If different than SSN)	Insc. Co. Phone #		
Insc. Co. Claims Address	City	State	Zip

Secondary Insurance? Y N

Subscriber			
Relationship to Patient	Subscriber's Birth Date	Subscriber's SSN#	
Employer of Subscriber			
Employer's Address	City	State	Zip
Insurance Company Name	Group #		
Insurance ID # (If different than SSN)	Insc. Co. Phone #		
Insc. Co. Claims Address	City	State	Zip

I authorize the dental staff to release any information including the diagnosis and the records of treatment or examination rendered during the period of my care or my child's care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Orthodontist insurance benefits otherwise payable to me. I agree to be responsible for all charges for orthodontic services not paid by my dental benefit plan. I understand my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I will notify this office of any change in the status of my insurance coverage that would effect payment for services rendered by this office.

Signature of patient: _____ Date: _____

Signature of parent or guardian of minor:_____ Date: _____
I have the legal authority to authorize treatment for this child.

Relationship:_____