OLSEN
ORTHODONTICS

Patient Information

Date

Patient's Name _____ I prefer to be called _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Who is your General Dentist? _____

Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____ # Years at address _____
Street City State Zip

Mailing Address _____ email _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ and Soc.Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Contact Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

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Medical History

Is the patient in good health? Yes _____ No_____

Does the patient have any history of major illness? Yes _____ No_____

If Yes, please describe_____

_____

For Women: Are you Pregnant? Yes _____ No _____

Check any of the following for which the patient has been treated:

Aids & HIV _____	Anemia _____	Prolonged Bleeding _____	Diabetes _____
Pneumonia _____	Epilepsy _____	Fainting or Dizziness _____	Heart trouble _____
Rheumatic Fever _____	Asthma _____	Nervous Disorders _____	Hepatitis _____
Osteoporosis _____	Kidney involvement _____	Endocrine Problems _____	Tuberculosis _____

Is the patient taking any medication for osteoporosis, or osteopenia? Yes_____ No_____

If yes, please give information about name of medication, dosage and how long it has been taken:

_____

List any other medications now being taken and give reasons for taking:

_____

List any allergies or drug sensitivities_____

Dental History

When was the patient's last visit to the dentist? _____

Is there any dental treatment still pending? _____

Does the patient have any heart condition for which antibiotics are taken before dental procedures? Yes____ No____

Has there been any injury to the face, mouth or teeth? Yes_____ No_____ Explain:_____

_____

Has the patient ever sucked a thumb or fingers? Yes_____ No _____ If yes, until what age? _____

Is the patient a mouth breather while awake? Yes _____ No_____ While asleep? Yes_____ No_____

Have you been informed of any missing or extra permanent teeth? Yes _____ No_____

Please share any other pertinent information regarding the patient's medical and dental history that has not been covered above:_____

*The information that I have provided is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's health history.
I also understand that where appropriate, credit bureau reports may be obtained.

_____ _____

Signature (Parent or guardian's signature if minor) Date