PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Birth date _____ ❒ Male ❒ Female

School _____ Grade _____ Home address _____

Home phone ( ) _____ City, State, Zip code _____

Cell phone ( ) _____ Other family members seen by us? _____

General Dentist _____ Date of last dental visit _____ Physician _____

How did you hear about our office? ❒ Insurance ❒ Dentist ❒ Patient _____ ❒ other _____

PARENT/ GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (check all that apply) ❒ Mother ❒ Father ❒ Stepmother ❒ Stepfather ❒ Grandparent(s) ❒ Other _____

RESPONSIBLE PARTY - **The parent or guardian who accompanies the child today is responsible for payment.**

A copy of your driver's license is required at the initial visit.

❒ Mr ❒ Dr Father's full name _____ Birth date _____

Relationship to patient: ❒ Father ❒ Step-Father ❒ Grandparent ❒ Other_____ Marital Status _____

Address (if different) _____ Social Security # _____

How long at this address_____ ❒ Own ❒ Rent Home phone ( ) _____ Cell phone ( ) _____

Employer _____ Occupation_____ # Years employed _____

Work phone ( ) _____ Email address(s) _____

❒ Ms ❒ Mrs ❒ Dr Mother's full name _____ Birth date _____

Relationship to patient: ❒ Mother ❒ Step-Mother ❒ Grandparent ❒ Other_____ Marital Status _____

Address (if different) _____ Social Security # _____

How long at this address_____ ❒ Own ❒ Rent Home phone ( ) _____ Cell phone ( ) _____

Employer _____ Occupation_____ # Years employed _____

Work phone ( ) _____ Email address(s) _____

DENTAL INSURANCE - **Please bring your insurance card to the first appointment**

PRIMARY policy holder's full name _____ Birth date _____

SSN or Member ID _____ Relationship to Patient _____ Policy holder's employer _____

Home Address (if different) _____ Group # _____

Insurance Company _____ Address _____ Insurance phone # ( )_____

SECONDARY policy holder's full name _____ Birth date _____

SSN or Member ID _____ Relationship to Patient _____ Policy holder's employer _____

Home Address (if different) _____ Group # _____

Insurance Company _____ Address _____ Insurance phone # ( )_____

I hereby authorize Olson & White to submit a claim on behalf of the aforementioned patient. I authorize my insurance company to pay the dental benefits to Richard J. White, D.D.S., L.L.C. I authorize the release of any information relating to this claim.

_____ _____

Signature Date

MEDICAL HISTORY:

Is patient in good health? ❒ Yes ❒ No HEIGHT: _____ WEIGHT: _____

Does patient have any history of major illness? ❒ Yes ❒ No Please explain: _____

Has the patient been treated for the following:

❒ Yes ❒ No Asthma
❒ Yes ❒ No Anemia
❒ Yes ❒ No Autism
❒ Yes ❒ No Bone Disorders
❒ Yes ❒ No Cancer, tumor, radiation or chemotherapy
❒ Yes ❒ No Diabetes
❒ Yes ❒ No Endocrine Problems
❒ Yes ❒ No Epilepsy
❒ Yes ❒ No Fainting or Dizziness
❒ Yes ❒ No Heart defects, heart murmur, rheumatic heart disease
❒ Yes ❒ No Hepatitis, jaundice, or other liver problems
❒ Yes ❒ No AIDS or HIV positive
❒ Yes ❒ No Kidney Involvement
❒ Yes ❒ No Nervous Disorders
❒ Yes ❒ No Pneumonia
❒ Yes ❒ No Prolonged Bleeding
❒ Yes ❒ No Rheumatic Fever
❒ Yes ❒ No Tuberculosis
❒ Yes ❒ No Other _____

Has your child had allergies or reactions to any of the following?

❒ Yes ❒ No Latex (gloves, balloons)
❒ Yes ❒ No Metals (jewelry, clothing snaps)
❒ Yes ❒ No Foods
❒ Yes ❒ No Other: _____

Please list any allergies or drug sensitivity _____

_____

Have Tonsils and Adenoids been removed? ❒ Yes ❒ No If yes, what age? _____

List any drugs or medications now being taken, give reasons: _____

Does your child take antibiotic pre-medication before any dental procedures? ❒ Yes ❒ No

DENTAL HISTORY:

Have there been any injuries to the face, mouth or teeth? ❒ Yes ❒ No If yes, please explain: _____

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

Does the patient have any speech problems? ❒ Yes ❒ No _____

Have you been informed of any missing or extra permanent teeth? ❒ Yes ❒ No _____

Has an Orthodontist been consulted previously? ❒ Yes ❒ No

Has either parent had orthodontic treatment? ❒ Yes ❒ No

List any musical instruments played: _____

REASON FOR CONSULTATION: _____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status. 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. I also authorize the dental staff to perform the necessary orthodontic services as needed. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office reserves the right to verify the credit status of potential patients and or/ parents prior to extending credit for treatment fees. I understand that where appropriate, credit bureau reports will be obtained.

Parent/Guardian Signature _____ Parent/Guardian Signature _____

Print Name _____ Print Name _____