Faber ORTHODONTICS

Simply Spectacular Smiles

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DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Member American Association of Orthodontists

PATIENT INFORMATION

LAST NAME	FIRST NAME	NICKNAME	SS NO.	SEX	BIRTH DATE	AGE

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

SCHOOL (if student)	GRADE		EMPLOYED BY/OCCUPATION	BUSINESS PHONE

EMAIL	CELL PHONE

WHO MAY WE THANK FOR RECOMMENDING US?	NAME OF DENTIST	DATE OF LAST VISIT

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE	NAMES & AGES OF OTHER CHILDREN
1	1
2	2

PARENT INFORMATION (please complete if patient is a minor)

FATHER'S NAME_____

ADDRESS (if different from patient's)_____

_____

CITY _____ ST _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ S.S NO._____

EMAIL _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

MOTHER'S NAME_____

ADDRESS (if different from patient's)_____

_____

CITY _____ ST _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ S.S NO._____

EMAIL _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY/OCCUPATION

PHYSICAL ADDRESS	CITY	STATE	ZIP

HOME PHONE	BUSINESS PHONE	CELL PHONE	EMAIL

IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?		
DENTAL INSURANCE COMPANY	POLICY HOLDER'S NAME	INSURED SS#
PHONE NUMBER INSURANCE COMPANY	INSURED DATE OF BIRTH	

Please check if patient has or has had

[Y] [N]		[Y] [N]	
[ ] [ ]	Joint swelling	[ ] [ ]	Tuberculosis
[ ] [ ]	Bone disorders	[ ] [ ]	Anemia
[ ] [ ]	Heart trouble	[ ] [ ]	Epilepsy (convulsions)
[ ] [ ]	Mitral Valve Prolapse	[ ] [ ]	Prolonged bleeding
[ ] [ ]	Rheumatic trouble	[ ] [ ]	Faintness/Dizziness
[ ] [ ]	Thyroid problems	[ ] [ ]	Tonsils removed
[ ] [ ]	Diabetes	[ ] [ ]	Adenoids removed
[ ] [ ]	Emotional problems	[ ] [ ]	Sore throats
[ ] [ ]	Brain injury	[ ] [ ]	Tonsillitis
[ ] [ ]	Kidney or liver involvement	[ ] [ ]	Earaches
[ ] [ ]	Joint Prosthesis	[ ] [ ]	Arthritis
[ ] [ ]	Hayfever, allergies	[ ] [ ]	Learning disabilities
[ ] [ ]	Asthma	[ ] [ ]	ADD/ADHD
[ ] [ ]	Tested Positive for HIV		

On items checked "Yes", please provide us with a more detailed description:

Please check if patient has or has had

[Y] [N]

[ ] [ ] Any injuries to face, mouth, teeth? (circle)
[ ] [ ] Thumb, finger, lip sucking? (circle)
[ ] [ ] More than average amount of decay?
[ ] [ ] Any missing permanent teeth?
[ ] [ ] Any extra permanent teeth?
[ ] [ ] Any teeth removed by extraction?
[ ] [ ] Any difficulty in swallowing or chewing?
[ ] [ ] Any pain or clicking on opening mouth?
[ ] [ ] Is patient adopted? At what age? _____
[ ] [ ] Does patient visit dentist regularly? Date of last visit _____
[ ] [ ] Any periodontal (gum) problems
[ ] [ ] Has an orthodontist been consulted previously?
[ ] [ ] How often do you brush _____ floss _____

Reason:

Approximately how much has patient grown in the last year?

Have you or any member of your family or close relative had:
Rheumatoid arthritis? [ ] Yes [ ] No Lupus? [ ] Yes [ ] No

What would you like to have orthodontic treatment accomplish?

List any other serious illnesses:

List any allergies:

Are you allergic to latex? Sensitive to metals (jewelry, snaps)

List drugs or medications now being taken?

Is patient presently under physician's care?
Reason:

Date last seen

Name of physician:
Primary:

Other:

Other:

Other:

Patient's attitude toward orthodontic treatment:
(circle one) Very motivated Will cooperate if needed Not motivated

Adolescent Females: Has menstruation begun? [ ] Yes [ ] No
Date (month/year)

Benefits

The benefits of Orthodontics include aesthetics, health and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Our teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment.

We do not accept divorce decrees as assignment of responsibility for a child's orthodontic bill. The parent accompanying the child to the office should pay for the services and seek any reimbursement from the other parent.

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 to further the art of science of orthodontics. I agree to inform this office of any changes in my medical or dental history. I authorize Dr. Faber permission to perform a complete orthodontic evaluation.

I understand a credit bureau report may be obtained.

_____ _____

Signature *Date*