LEAVER & SIMISTER
ORTHODONTICS

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Date _____

Confidential Patient Information

Patient's Name _____ (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? _____

Confidential Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) Marital Status _____

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work 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 _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

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

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

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? ☐ Yes ☐ No If yes:

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

Insurance Co. _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (Date & Initial) _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

MEDICAL HISTORY

GENERAL DENTIST _____ LAST CLEANING _____

IS PATIENT IN GOOD HEALTH? _____ ❑ YES ❑ NO

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS _____ ❑ YES ❑ NO

PLEASE LIST _____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED

AIDS & HIV . . . . . ❑	Anemia . . . . . ❑	Prolonged Bleeding . . . ❑
Diabetes . . . . . ❑	Epilepsy . . . . . ❑	Fainting or Dizziness . . ❑
Pneumonia . . . . . ❑	Asthma . . . . . ❑	Nervous Disorders . . . . ❑
Heart Trouble . . . . ❑	Kidney Involvement . . ❑	Hepatitis . . . . . ❑
Rheumatic Fever . . ❑	Tuberculosis . . . . . ❑	Endocrine Problems . . ❑
Bone Disorders . . . ❑		

DOES PATIENT HAVE TENDENCY TO COLDS? ❑ SORE THROATS? ❑ EAR INFECTIONS ❑

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ ❑ YES ❑ NO

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS _____

_____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAS THE PATIENT REACHED PUBERTY? — GIRLS - HAS SHE STARTED MENSTRUATION? ❑ YES ❑ NO

BOYS - HAS HIS VOICE CHANGED? ❑ YES ❑ NO

HEIGHT _____ WEIGHT _____

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ ❑ YES ❑ NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ ❑ YES ❑ NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ ❑ YES ❑ NO

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

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____ ❑ YES ❑ NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ ❑ YES ❑ NO

LIST ANY MUSICAL INSTRUMENTS PLAYED _____

REASON FOR CONSULTATION _____

_____