Date of Exam ________________

General Information

Patient's Full Name ______________________________ Nickname ______________
Date of Birth ____________ Age ____________ Sex ________
Address ______________________________ Email ______________
Cell ______________ Home ______________ Work ______________
Occupation ______________ SS# ______________
Employer ______________ Address ______________
Name of Responsible Party for Account ______________ (appropriate credit bureau info may be obtained)
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single
Name of Spouse ______________ Date of Birth ____________ SS# ____________
Occupation ______________ Employer ______________
Employer's Address ______________ Phone ______________
Do you have orthodontic insurance? Yes☐ No☐ Name of Company ______________
What encouraged you to select our office for treatment? ______________

Medical History

Are you in good health? Yes ☐ No☐ Name of Physician: ______________
Do you have any history of major illness? Yes ☐ No☐ List: ______________

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Have you had tonsils and/or adenoids removed? Yes ☐ No☐ What age? ______________
List any drugs or medications now being taken. Give Indications: ______________
Do you have any allergies or drug sensitivity? ______________

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

Diabetes ☐	**Anemia** ☐	**Prolonged Bleeding** ☐
Pneumonia ☐	**Epilepsy** ☐	**Fainting or Dizziness** ☐
Heart Trouble ☐	**Endocrine Problems** ☐	**Anxiety Disorders** ☐
Rheumatic Fever ☐	**Kidney Problems** ☐	**Liver Involvement** ☐
Bone Disorders ☐	**AIDS** ☐	**ADD/ADHD** ☐
Tuberculosis ☐	**Hepatitis** ☐	**Asthma** ☐

Dental History

Name of current Dentist: ______________ Date of last dental visit ____________ Cavities? Yes☐ No☐
Is there history of trauma to face, mouth, or teeth? .... Yes☐ No☐ ______________
Do you have any speech problems? .... Yes☐ No☐ ______________
Are you a mouth breather? .... Yes☐ No☐ ______________
Have you been informed of extra or missing permanent teeth? .... Yes☐ No☐ ______________
Has an orthodontist been consulted previously? .... Yes☐ No☐ ______________
Has anyone in family had orthodontic treatment? .... Yes☐ No☐ ______________
What encouraged you to seek orthodonntic treatment? ______________

Adult

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Signature

Credit Authorization

I hereby authorize **OrthoBanc, LLC**, on behalf of **Thomas & Leitner Orthodontics, LLC** to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

____
Responsible Name Printed

____
Responsible Signature

____
Responsible Social Security Number