



Date of Exam _____

General Information

Patient's Full Name _____ Nickname _____
Date of Birth _____ Age _____ Sex _____ School _____
Address _____ Home Phone _____
Mother's Name _____ Date of Birth _____ Email _____
Address _____ SS# _____
Occupation _____ Cell _____ Home _____ Work _____
Employer _____ Address _____
Father's Name _____ Date of Birth _____ Email _____
Address _____ SS# _____
Occupation _____ Cell _____ Home _____ Work _____
Employer _____ Address _____
Name of Responsible Party for Account _____ (appropriate credit bureau info may be obtained)
Parents Marital Status: [] Married [] Divorced [] Separated [] Single
Do you have orthodontic insurance? Yes [] No [] Name of Company _____
What encouraged you to select our office for treatment? _____
Names and Ages of other Children in Family _____

Medical History

Is patient in good health? Yes [] No [] Name of Physician: _____
Does patient have any history of major illness? Yes [] No [] List: _____
Has patient had tonsils and/or adenoids removed? Yes [] No [] What age? _____
List any drugs or medications now being taken. Give Indications: _____
Does patient have any allergies or drug sensitivity? _____
Has patient reached puberty? Girls (started menstruation) Yes [] No [] Boys (voice changed) Yes [] No []

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 []
Has the patient ever sucked a thumb or fingers? Yes [] No []
Does the patient have any speech problems? Yes [] No []
Is the patient 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 []
List any musical instruments played: _____
What part of your child's orthodontic problem concerns you most? _____

Adolescent

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