Patient/Parent Information

eberle orthodontics

Nicole E Eberle, DDS, MS

Patient Information

Name: _____ Prefers to be called: _____

Home Address: _____Home Phone:

Patient's Birthdate: _____ Age: _____ Gender: _____ School: _____ Grade: ___

If a minor: Parent's Name _____ Marital Status: ☐M ☐S ☐D ☐W

Parent's Name _____

Who does patient live with? _____ Have we treated another member(s) of your family? _____

Whom may we thank for referring you? _____

Responsible Party Information #1

Name _____ Phone _____

Address _____ City _____ Zip _____

Email Address _____ Home Phone _____ Work Phone _____

Cell Phone _____ Employer _____

Occupation _____ Years employed _____

Social Security #: _____ Birthdate _____

Responsible Party Information #2

Name _____ Phone _____

Address _____ City _____ Zip _____

Email Address _____ Home Phone _____ Work Phone _____

Cell Phone _____ Employer _____

Occupation_____ Years employed _____ Birthdate _____

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____

Insurance Company Name _____ Address_____ Phone Number _____

Social Security or ID Number _____ Group Number _____

Group Name _____ Do you have dual coverage? Yes ☐ No ☐

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____

Insurance Company Name _____ Address_____ Phone Number _____

Social Security or ID Number _____ Group Number _____

Group Name _____

Patient Care Information

eberle orthodontics

Nicole E Eberle, DDS, MS

General Dentist

Name _____ Date of last visit_____

_____ _____ _____

City State Zip

Family Physician

Name _____ Date of last visit_____

Are you under the care of a physician? Yes ☐ No ☐

Please explain: _____

Are you taking any prescription/over-the-counter drugs? Yes ☐ No ☐

Please explain: _____

Do you require antibiotic pre-medication prior to dental work/cleanings? Yes ☐ No ☐

Medical History

Have you ever had any of the following diseases/medical conditions?

Abnormal bleeding	Yes ☐	No ☐	Hearing Impairment	Yes ☐	No ☐
Allergies to drugs	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Hemophilia/Abnormal bleeding	Yes ☐	No ☐
Difficulty breathing	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Epilepsy/Seizures/Fainting	Yes ☐	No ☐	Periodontal Disease	Yes ☐	No ☐
Fever blisters/Herpes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Handicaps/Disabilities	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐

Your current physical health is: Good ☐ Fair ☐ Poor ☐

Please list any serious medical conditions you have had: _____

Please list any drug/substances that you are allergic to: _____

Are you allergic to Nickel? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ Use chewing tobacco? Yes ☐ No ☐

If female, is there any possibility you are pregnant? Yes ☐ No ☐ Trimester _____

If the patient is an adolescent, please answer the following:

Height: _____ Recent growth? Yes ☐ No ☐ How much? _____ Weight _____

Boys: Has his voice changed? Yes ☐ No ☐ Girls: Has she begun menstruation? Yes ☐ No ☐

Dental History

Do you like to smile? Yes ☐ No ☐ Do your gums ever bleed? Yes ☐ No ☐

Have you ever had a serious/difficult problem associated with any previous dental work? Yes ☐ No ☐

If yes, please list: _____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes ☐ No ☐

Have you ever had an injury to your: Mouth ☐ Teeth ☐ Chin ☐

Do you know if you have any missing/extra permanent teeth? Yes ☐ No ☐

Do you have/have you ever had any speech impediments? Yes ☐ No ☐

If yes, please list: _____

Do you generally breathe through your mouth while you sleep? Yes ☐ No ☐

Have you ever had or been evaluated for orthodontic treatment? Yes ☐ No ☐

If yes, when? _____

Child Habits

If patient is a child, does/did your child have any of the following habits?

Clenching/Grinding teeth	Yes ☐	No ☐	Nursing bottle habits	Yes ☐	No ☐
Lip sucking/Biting	Yes ☐	No ☐	Speech impediments	Yes ☐	No ☐
Mouth breathing	Yes ☐	No ☐	Thumb/Finger sucking	Yes ☐	No ☐
Nail biting	Yes ☐	No ☐			

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____