LELAND ORTHODONTICS

Thank you for selecting Leland Orthodontics. Please complete all fields below to the best of your ability. If you need assistance, please ask our staff. Thank you.

New Patient Registration

Patient Information:

Date: _____

First Name: _____ Last Name: _____

Birth date: _____ Sex: ☐ Male Female

Phone #: _____ Text Ok? YES NO Phone Carrier: _____

Email: _____ School: _____

Address: _____ City: _____ Zip Code: _____

Emergency Contact Name: _____ Phone: _____

How did you first hear about Leland Orthodontics?: _____

Dentist Information:

Patient's Dentist: _____ Location: _____

Phone #: _____ Last Seen: _____

Are there any dental related problems you would like us to know about?_____

_____

Financial Information:

Who is financially responsible for your account? Name: _____

Address (if different than patient's): _____

Phone #: _____ Email: _____

Insurance Information (if applicable):

☐ I will **not** be using insurance ☐ I do not know if I have orthodontic coverage, please verify

Insurance Company: _____ ID# _____

Group #: _____ Employer: _____

Primary Policy Holder's Name: _____ Date of Birth: _____

SSN#: _____

Medical Information: *Your answers are for office records only, and are confidential*

Now or in the past have you had:

YES	NO	Please check all
		Birth Defects or hereditary problems?
		Any injuries to face, neck, head?
		Endocrine or thyroid problems?
		Diabetes or low blood sugar?
		Cancer, tumor, radiation treatment, chemotherapy?
		Immune system problems?
		Gonorrhea, syphilis, herpes, sexually transmitted diseases?
		AIDS or HIV Positive?
		Polio, mononucleosis, tuberculosis, pneumonia?
		Seizures, fainting spells, neurologic problems?
		Mental health disturbance or depression?
		Vision, hearing or speech problems?
		History of eating disorder?
		High or low blood pressure?
		Excessive bleeding or bruising, anemia?
		Heart Defects? Strokes / heart attacks?
		Frequent headaches or migraines?
		Asthma, sinus problems, hayfever?
		Tonsil or adenoid condition?
		Do you frequently breath through your mouth?
		Do you chew or smoke tobacco?
		Are you pregnant or trying to become pregnant?
		Do you have a substance abuse problem?
		Do you take antibiotic pre-medication before any dental procedure?

Please list allergies *(ex: latex, metals, local anesthetics):* _____

_____

Please list all medications: _____

_____

Is there anything else in your medical history you would like us to know about? _____

_____

What is your favorite food? _____

What is your favorite place to vacation? _____

Orthodontic Goals:

What concerns you about your teeth: _____

_____

What are your goals for Orthodontic treatment: _____

_____

Have you had Orthodontic treatment before? If yes when/where: _____

_____

Why did you choose Leland Orthodontics?: _____

Release and Waiver:

I authorize release of any information regarding my orthodontic treatment to my dental insurance company:

Signature: _____ Date: _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature: _____ Date: _____

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