Keith B. Dressler, D.D.S., M.S.D.
Board Certified Specialist in Orthodontics for Children and Adults

www.drdressler.com

Date _____ Referred By _____

PATIENT _____
First Middle Last name we should call you

Address _____
Street City/State Zip

Phone _____/_____/_____ Soc. Sec. # _____
Home Work Cell

Birth date _____ Employment/School _____

Email _____ Dentist _____ Physician _____

MOTHER _____
(Spouse if Adult) First Middle Last name we should call you

Address _____
Street City/State Zip

Phone _____/_____/_____ Soc. Sec. # _____
Home Work Cell

Birth date _____ Employment/School _____

Email _____

FATHER _____
(Skip if Adult) First Middle Last name we should call you

Address _____
Street City/State Zip

Phone _____/_____/_____ Soc. Sec. # _____
Home Work Cell

Birth date _____ Employment/School _____

Email _____

OTHER Parents Marital Status _____ Patient lives with _____

Siblings _____
Names and Ages

Emergency Contact information _____
(Other than home info)

FINANCIAL INFORMATION

Financially Responsible Party #1 _____

Relationship to Patient _____ Soc. Sec. # _____

Insurance Company Name / Address / Phone _____

Group # _____ Policy # _____

Employer Name / Address / Phone _____

Financially Responsible Party #2 _____

Relationship to Patient _____ Soc. Sec. # _____

Insurance Company Name / Address / Phone _____

Group # _____ Policy # _____

Employer Name / Address / Phone _____

CHIEF COMPLAINT

What are your chief concerns regarding the patients orthodontic condition? (overbite, crowding, etc.)

Please describe your reason for considering orthodontic treatment.

- ○ Improved facial appearance
- ○ Improved functional health
- ○ Enhanced long term dental health
- ○ Other _____

Please describe the patient's attitude toward orthodontic treatment.

- ○ Eager
- ○ Complacent
- ○ Antagonistic

Turn to continue

MEDICAL HISTORY

Does the patient have a history of any of the following?
Check when yes

- ❑ Asthma
- ❑ Diabetes
- ❑ Blood Disorder
- ❑ Epilepsy
- ❑ Hepatitis
- ❑ Heart problems
- ❑ Glaucoma
- ❑ Rheumatic fever
- ❑ Ear problems
- ❑ Tonsil or adenoid removal _____ At what age?
- ❑ HIV
- ❑ Tuberculosis
- ❑ Allergies (if yes, please list) _____
- ❑ Latex
- ❑ Nickel
- ❑ Is the need for orthodontic treatment caused by an accident?
  If so, please give date and description. _____

Is the patient?
Check when yes

- ❑ In good health
- ❑ Under a physician's care
  If so, for what reason?

  _____
  _____

- ❑ Taking any medication
  if yes, please list

  _____
  _____

Please note any **other factors** the doctor should know about the patients health.

_____
_____

DENTAL HISTORY

- ❑ Thumb or finger sucking (Presently)
- ❑ Thumb or finger sucking (Previously)
- ❑ Had primary teeth removed
- ❑ Had permanent teeth removed
- ❑ Speech problems
- ❑ Swallowing problems
- ❑ Injury to face or teeth
- ❑ Night time teeth grinding
- ❑ Mouth Breathing (❑ Night time only)
- ❑ Sleeps on side or stomach
- ❑ Takes in caffeine, sugar, or carbonated beverages two or more times a day.
- ❑ Patient has been in an auto accident
- ❑ Bites fingernails

- ❑ Recent dental check -up
  Date: _____
- ❑ Previous orthodontic treatment
  Date: _____
  By whom? _____
- ❑ Previous examination by an orthodontist
  Date: _____
  By whom? _____

Please note any **other factors** doctor should know about the patients dental health.

_____

_____

AUTHORIZATION

The Patient (Guardian) agrees to notify Dr. Dressler if any changes occur in their medical / health history. The Patient (Guardian) agrees to be fully responsible for the total payment of procedures performed in this office including any amounts which are not covered by any dental insurance or other payment programs. We allow 90 days for the payment of insurance coverage thereafter it is the patient's responsibility of payment. In the event of nonpayment of treatment costs the Patient (Guardian) agrees to be responsible for any collection fees, attorney fees, or other fees necessary to collect the Patient's (Guardian) account. In the process of reviewing this information, we may find it necessary to obtain a copy of your credit through a credit reporting agency. I authorize the release of medical and dental information to insurance carriers and to other health care providers involved in the care of this patient.

I have read and thoroughly understand the above policies of this office.

_____ Date

_____ Signature of Parent or Guardian