Thank you for choosing our office. We're glad you're here.

Please fill out the following patient information form completely.

Date: _____
Patient's Name _____Preferred Name _____
Gender: M or F
Date of Birth:_____ Age _____School _____ Grade ____
Address _____
Street City State Zip

General Dentist_____
Whom may we thank for recommending you to our office _____

Responsible Party Information

Parent ___ Self ___ Legal Guardian ___ Name: _____
Relationship to Patient_____
Marital Status: Married ___ Separated ___ Divorced ___ Widowed ___ Single ____
Name of Spouse (if applicable) _____
Address _____
Street City State Zip
Phone: Home _____ Cell _____ Work _____
Occupation _____ Employer _____
Best time to reach you _____

Insurance Information

Primary Card Holders Name _____
Address _____
Street City State Zip
Date of Birth _____ Social Security # __ __ __ - __ __ - __ __ __
Relationship to Patient _____
Employer _____ Number of years employed _____
Primary Insurance Carrier _____
Group Number _____ Contact Number _____
Lifetime Maximum Amount of Orthodontic Coverage $_____
Is there a waiting period before benefits can be used? _____

I, _____, authorize Dr. Stephen Ollard's office to file claims directly to my insurance carrier for services rendered in accordance with current insurance standards, for procedures performed during orthodontic treatment. I understand and agree that any portion of the expected insurance contribution that is not paid by the insurance carrier for any reason is my responsibility to pay in a timely manner consistent with the contract payment schedule agreed upon before the start of treatment. I further understand that it is the responsibility of the patient/parent/myself to notify Dr. Ollard's office if insurance is cancelled or changed in any way that would affect payment for services rendered.

Signature _____ ***Date*** _____

Dr's Notes: _____
_____
_____
_____

Medical History

Is the patient:

In good health? __ Yes __ No Explain: _____
Being treated by a physician? __ Yes __ No Explain: _____
Currently taking medication? __ Yes __ No Explain: _____

Does the patient have:

Any major or unusual illnesses? __ Yes __ No Explain: _____
Allergies? __ Yes __ No List: _____
Drug Sensitivities? __ Yes __ No List: _____

Please check the appropriate box if the patient has or has had any of the following:

Yes	No		Yes	No		Yes	No	
___	___	Anemia	___	___	Heart Problem	___	___	Frequent Cold/Flu
___	___	Blood Disease	___	___	Tuberculosis	___	___	Tonsillitis
___	___	Diabetes	___	___	Adenitis	___	___	Prolonged Disease
___	___	Jaundice	___	___	Hepatitis	___	___	Tonsils Removed Age ___
___	___	Scarlet Fever	___	___	Epilepsy	___	___	Adenoids Removed Age___
___	___	Asthma	___	___	Herpes	___	___	Endocrine Problems
___	___	Bone Disorders	___	___	Glaucoma	___	___	Rheumatic Fever

___ ___ Is the patient exposed to/at risk for HIV/AIDS
___ ___ Mouth Breathing: While awake _____ While Asleep _____

Dental History

Names & Ages of Brothers/Sisters:

_____
Have any of them had orthodontic treatment? ___ Yes ___ No
Did either parent have orthodontic treatment? ___ Mother ___ Father ___ Neither
Name of prior Orthodontist: _____

Has the patient:

___ Yes ___ No had any severe head/face injuries?
If yes, explain: _____
___ Yes ___ No had a history of thumb/finger sucking? Stopped when _____
___ Yes ___ No consulted an orthodontist before?
___ Yes ___ No had any previous orthodontic treatment?
If yes, explain: _____
___ Yes ___ No Does the patient play any musical (wind) instruments? What? _____

Please check if there is a history of:

___ Clenching Teeth	**___ Headaches (more than normal)**	**___ Jaw joint popping**
___ Grinding Teeth	**___ Ringing in the ears**	**___ Jaw joint soreness**
___ Muscular soreness around head and/or neck		**___ Jaw joint clicking**

Is there any other information that may be helpful? _____
_____

Signed **_____** ***Date*** **_____**

AS YOU CONSIDER BRACES….
SOME THOUGHT AND TIPS TO THINK ABOUT
BEFORE STARTING ORTHODONTIC TREATMENT

HOW LONG WILL IT TAKE?

The actual treatment time will vary depending upon the amount of tooth movement necessary, the rate of growth of the patient, and the degree of cooperation by all parties involved. Most orthodontic treatment takes about 2 years to complete. Easier cases may be completed in a year, while more difficult cases may take 3 or more years to finish. Successful, timely orthodontic treatment depends on full cooperation of the patient and their parent(s) or guardian(s).

HOW OFTEN WILL WE NEED TO SEE THE ORTHODONTIST?

Braces require constant adjustment in order to work. Generally, you can plan on visiting us every 4-6 weeks. Neglected braces can permanently damage the teeth and gums, therefore **failure to keep scheduled appointments will make it necessary for us to remove the braces and discontinue treatment.**

WHAT TYPE OF SPECIAL CARE WILL BRACES NEED?

Patients wearing braces need to avoid hard or sticky foods. Chewing on pens, pencils, or fingernails can also damage braces. Some foods that usually would be eaten whole (ex apple), will need to be cut up into bite-sized pieces. Damaged braces will not only extend the treatment time, and require additional appointments, but can cause the teeth to be moved in the wrong direction.

For many patients, braces alone may not be enough to complete the necessary treatment. Many patients will be required to wear rubber bands along with the braces. Rubber bands must be put on several times a day.

It is very important that the teeth and gums are kept clean during treatment. Lack of brushing and flossing every day can cause severe and permanent damage to both the teeth and gums. Teeth can be discolored with permanent white or brown spots. Gums can be damaged where surgery will be needed for repair. We will teach the patient and/or parent(s) or guardian(s) how to keep the teeth, gums, and braces in good condition.

Before braces can be placed, the patient will need to visit their regular dentist for an examination, cleaning, fluoride treatment, and any necessary fillings. During orthodontic treatment, the patient will continue to visit their regular dentist for check-ups and cleanings every 6 months.

Damaged or neglected braces can cause serious damage to teeth and gums. Multiple broken or damaged braces, and/or lack of daily brushing and flossing will require us to remove the braces and stop treatment.

WILL HAVING BRACES HURT?

Many patients feel some minor discomfort for a few weeks when the braces are initially placed. This is due to the cheeks and gums getting accustomed to the braces. After each adjustment, the

teeth may be a bit sore for a couple of days. The discomfort is easily managed with medication that you would take for a headache.

HOW IMPORTANT IS PATIENT AND FAMILY COMMITMENT TO SUCCESSFUL TREATMENT?

Successful orthodontic treatment is a two-way street. It takes cooperation and commitment on the part of the doctor, the patient, and their family to ensure timely completion and a pleasing result. Since permanent damage can occur through abuse and/or neglect of the teeth and braces, we will require a strong commitment on part of both the patient as well as the parent/guardian before they will recommend for treatment to begin.

I understand the commitment it will take on part of me as well as my child to ensure that the proposed orthodontic treatment is competed successfully and in a timely fashion. I have discussed with my child their responsibilities to avoid hard and sticky foods, keep all scheduled appointments, follow all directions, and brush and floss daily. **I understand that 3 consecutive broken appointments, excessive broken or damaged braces, inability to brush and floss daily, and/or failure to cooperate during treatment will cause the removal of braces and discontinuation of treatment.**

_____

Parent/Guardian Signature **Date**