Welcome to the Orthodontist

Our purpose is to provide the highest quality orthodontic care with a skilled staff, educated in current technologies. We strive to provide clear communication, exceed expectations and give patients and families a positive orthodontic experience.

Rebecca Berg D.M.D., M.D.S.

Patient Information

Patient Name: _____ Date: _____/_____/_____
Last First Middle

School: _____ Sex: ❑ Male ❑ Female Age: _____ Birthdate: _____/_____/_____

If Patient is a Minor, Give Parent's or Guardian's Name with Whom the Patient Lives _____

Whom May We Thank for Referring You to our Office? _____

Patient/Parent Primary Concern: _____

Person Responsible for Account

(In the Case of a Minor, the Responsible Party is the Parent or Guardian with Whom the Patient Lives)

Name: _____ Marital Status: _____
Last First Middle

Address: _____
Street City State Zip

Email Address: _____@_____

Years at Address: ____ Home #: _____Work #: _____Cell #: _____

Soc. Sec. No. _____ Birthdate: ____/____/____ Relationship to Patient: _____

Employer: _____ Occupation: _____# Yrs Employed: _____

Spouse's Name: _____ Relationship to Patient: _____
Last First Middle

Employer: _____ Occupation: _____# Yrs Employed _____

Soc. Sec. No. _____ Birthdate: ____/____/____ Work Phone: _____

Dental Insurance Information

Dental Coverage: ❑Yes ❑No Orthodontic Coverage: ❑Yes ❑No

Primary Insured's Name: _____ Insured's Soc. Sec. No. _____

Dental Insurance Company: _____ Group #: _____

Dental Insurance Company Address: _____ Phone #: _____

Secondary Insured's Name: _____ Insured's Soc. Sec. No. _____

Dental Insurance Company Address: _____ Phone #: _____

I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO MY OR MY CHILD'S INSURANCE CLAIM. I HEREBY AUTHORIZE PAYMENT TO KIM FITZGERALD D.M.D. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Signed: _____ Date: _____

Emergency Information

Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____ Work #: _____

PLEASE CONTINUE ON REVERSE

Patient Dental History

Dentist's Name: _____ Last Dental Exam: _____

Dentist's Address: _____ Phone #: _____

Who first noticed the need for an orthodontic examination? ❑ Dentist ❑ Parent ❑ Patient

	YES	NO	EXPLAIN
Has anyone in the family ever had orthodontic treatment?			
If so, has the result been stable and satisfactory?			
Has the patient had any teeth removed?			
Is the patient concerned about the appearance of the teeth?			
Has the patient ever been teased about the appearance of the teeth?			
Is the patient worried about receiving orthodontic treatment?			
Has the patient had previous orthodontic treatment or consultation?			
Does the patient have difficulty chewing and swallowing food?			
Does the patient have any speech problems?			
Does the patient grit, grind or clench the teeth?			
Has the patient ever sucked a thumb or finger? If so, until what age?			
Does the patient bite lips, tongue, fingernails, pencils, other?			
Does the patient breathe through the mouth?			
Do the gums bleed easily?			
Has the patient ever received a severe blow to the teeth or jaws?			
Have there been any other injuries to the face, mouth or teeth?			
Does the patient have frequent earaches or soreness around the ears?			
Does the patient have clicking or popping of the joint in front of the ear?			
Has the jaw ever locked open or closed? Open ___ Closed ___			
If so, when did it first occur? How often?			
Do you consider the patient to be under more stress than most people?			
Does the patient have difficulty in opening the mouth wide?			
Does the patient play a musical instrument? If so, which one?			

CHILDREN ONLY: Has the patient reached puberty? ____ Height: _____ Weight: _____ Is patient an adopted child? _____
GIRLS: Has she started menstruation? ____ When? _____ BOYS: Has his voice changed? _____ When: _____

Patient Medical History

Physician's Name: _____ Phone #: _____

	YES	NO	EXPLAIN
Is the patient in good health?			
Is the patient currently under the care of a physician?			
Does the patient have a tendency to colds, sore throats, ear infections?			
Have tonsils and adenoids been removed? What age?			
Any drugs or medications now being taken: If so, please list			
Have you ever taken the category of medications called 'bisphonates' or been treated for osteoporosis, bone cancer or Paget's disease?			

Has the patient any history or difficulty with any of the following:

____Allergies
____Arthritis
____Artificial Joints
____Asthma
____Bleeding Disorder
____Bone Disease
____Cancer
____Chronic Cough
____Chronic Sinus Problems
____Chemical Dependency
____Cold Sores/ Mouth Ulcers
____Congenital Heart Lesions
____Convulsions
____Diabetes
____Endocrine Disturbances
____Epilepsy
____Fainting
____Growth Disturbances
____Hearing Problems
____Heart Conditions/Murmur
____Hepatitis
____High Blood Pressure
____HIV/AIDS
____Kidney Disturbances
____Latex or Nickel Allergy
____Learning Disability
____Liver Disease
____Mental Problems
____Mitral Valve Prolapse
____Nervous Disorders
____Pain in the Face
____Pregnancy – Due date _____
____Respiratory Problems
____Rheumatic Fever
____Serious Illness
____Sexually Transmitted Disease
____Skin Rash
____ Stomach Problems
____ Stroke
____Thyroid
____Tuberculosis
____Vision Problems

Are there any other conditions the orthodontist should know about? _____

Are you a tobacco user? ❑ Yes ❑ No

TO THE BEST OF MY KNOWLEDGE ALL OF THE PRECEEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM THE DOCTORS AT THE NEXT APPOINTMENT.

Signature (Parent's Signature if a Minor) _____

UPDATES (Date & Initial) _____ _____ _____ _____ _____ _____ _____ _____