ERNSTBERGER ORTHODONTICS

Seth Ernstberger, DMD

Welcome to EO!

New Patient Registration…

(for patients under age 18) Today's Date _____

Patient Name _____ Preferred Greeting/Nickname _____

Home Address _____ City/State/Zip _____

Home Phone _____ Birthday _____ Age _____ Sex □ M □ F

Emergency Contact *(non-relative, not living with you)*: _____ Phone _____

Primary Care Dentist _____ Primary Care Physician _____

In your opinion, what is your top orthodontic concern/problem? _____

School _____ Who may we thank for referring you to our office? _____

Father's Name _____ Birthday _____ Phone _____

Father's Occupation _____ Employed By _____

Mother's Name _____ Birthday _____ Phone _____

Mother's Occupation _____ Employed By _____

Father's Work/Cell Phone _____ Mother's Work/Cell Phone _____

Email Address *(only used for reminders and updates)* _____

Siblings and Ages _____

If divorce is involved, who is the Custodial Parent? _____

May information be released to the non-custodial parent? □ Yes □ No

Person Responsible for Account _____

Social Security # _____ Birthday _____ Age _____ Sex □ M □ F

Address _____ City/State/Zip _____

Do you have orthodontic insurance coverage? □ Yes □ No Company _____

Group/Policy Number _____ Phone Contact _____

ERNSTBERGER ORTHODONTICS

Dental/Medical Health Questionnaire…

Today's Date _____

Patient Name _____ Birthday _____

Primary Care Dentist _____ Date of Last Visit _____

Have you ever had the following dental treatment?

- ☐ Orthodontics… Dates: _____ Doctor: _____
- ☐ Periodontal Treatment ("gum" surgery/treatment)… Doctor: _____
- ☐ Mouthguard/Splint Therapy (for jaw joint problems)…
- ☐ Jaw Surgery to change your bite or correct jaw joint…

Do you have or have you ever had any of the following oral conditions?

- ☐ Sensitive Teeth
- ☐ Clenching/Grinding
- ☐ Bad Breath
- ☐ Pain in the Face/Jaw
- ☐ Dry Mouth
- ☐ Poorly Functioning Teeth
- ☐ Bleeding Gums
- ☐ Pain Around Ear
- ☐ Mouth-breathing
- ☐ Thumb/Finger-sucking Habit
- ☐ Painful Opening
- ☐ Discolored Teeth
- ☐ Food Wedging/Impaction
- ☐ Swelling or Lumps in Mouth
- ☐ Tobacco Use
- ☐ Jaw Joint Sounds/Pain
- ☐ Difficulty Flossing Between Teeth
- ☐ Jaw gets Stuck (open or closed

Have or ever had any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Rheumatic Fever	☐	☐	Congenital Heart Lesions/Murmur	☐	☐	Arthritis, Swollen Joints
☐	☐	Diabetes	☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Inflammatory Rheumatism	☐	☐	Kidney Problems	☐	☐	Hepatitis (Type _____)
☐	☐	Asthma	☐	☐	Yellow Jaundice	☐	☐	Low Blood Pressure
☐	☐	Liver Disease	☐	☐	High Blood Pressure	☐	☐	Convulsions or Seizures
☐	☐	Severe Headaches	☐	☐	Dizziness or Fainting	☐	☐	Sinus Problems
☐	☐	Eye Problems	☐	☐	Ear Problems	☐	☐	Swallowing Problems
☐	☐	Nose Bleeds	☐	☐	Speech Problems	☐	☐	HIV Positive
☐	☐	Easy Bruising	☐	☐	Venereal Disease	☐	☐	Other (not listed) _____
☐	☐	ADD/ADHD	☐	☐	Heart Condition			

Currently under the care of a physician? _____ Yes No

Ever been hospitalized or treated for a serious illness? _____ Yes No

Any drug allergies? If yes, please list medications. _____ Yes No

Any allergies to metal, latex, or vinyl products? If yes, please explain. _____ Yes No

Currently taking any medications? If yes, please list them. _____ Yes No

Female Patients: Is there any possibility of pregnancy at the present time? _____ Yes No

Ever taken any diet medication (Phen-Fen)? _____ Yes No

Patient/Parent/Guardian Signature _____ Date _____

Dr. Seth's Signature _____

Additional Notes: _____

_____