Welcome to Dr. Alena Spielberg's Office!

Please take a few moments to fill out this necessary information that will enable us to better serve you.
Our staff will be happy to assist you with any questions you may have.

PATIENT INFORMATION

Patient's Name:______________________ Age:________ DOB:______________ Sex: M / F

Address:______________________________ City:______________ State:______ Zip:________

Does the patient play a musical instrument? Y / N Which?______________________________

Does the patient play any sports? Y / N Which?______________________________

Other interests, hobbies or extracurricular activities:______________________________

RESPONSIBLE PARTY INFORMATION

Mother's Name:______________________ DOB:______________ SSN:________ -______-________

Home Phone:______________ Cell Phone: ______________ Email Address:______________________

Address:______________________________ City:______________ State:______ Zip:________

Employer:____________________ Occupation:______________ Work Phone: ______________

Employer Address:______________________________ City:______________ State:______ Zip:________

Insurance Provider:______________ Phone:______________ ID#:____________ Group#:____________

I have Orthodontic Coverage: ☐ Yes ☐ No I will be utilizing my Orthodontic Coverage: ☐ Yes ☐ No

Father's Name:______________________ DOB:______________ SSN:________ -______-________

Home Phone:______________ Cell Phone: ______________ Email Address:______________________

Address:______________________________ City:______________ State:______ Zip:________

Employer:____________________ Occupation:______________ Work Phone: ______________

Employer Address:______________________________ City:______________ State:______ Zip:________

Insurance Provider:______________ Phone:______________ ID#:____________ Group#:____________

I have Orthodontic Coverage: ☐ Yes ☐ No I will be utilizing my Orthodontic Coverage: ☐ Yes ☐ No

I have verified that all of the above information is correct. I understand this information may be used to obtain my credit report. Such report will be utilized in determining payment options specific to me. I also understand Dr. Spielberg's staff will file with my primary insurance and I will be responsible for filing any additional claims thereafter.

Patient Signature:______________________________ **Date:**____________

Parent/Guardian Signature: ______________________________ **Date:**____________

MEDICAL HISTORY

Physician:______________________ Phone:______________ Last Visit:__________

Address:______________________ City:______________ State:______ Zip:________

Is the patient presently under a physician's care? Y / N For what condition?______________________

IS THERE ANY IMMEDIATE FAMILY HISTORY OF: (PLEASE CIRCLE)

Y / N	Heart Disease	Y / N	Kidney Disease	Y / N	Nasal Blockage	Y / N	Emotional Problems
Y / N	Rheumatic Fever	Y / N	Diabetes	Y / N	Drug/Alcohol Use	Y / N	Psychiatric Therapy
Y / N	Heart Murmur	Y / N	Seizures	Y / N	Hepatitis/Jaundice	Y / N	Digestive Disorder
Y / N	Asthma	Y / N	High Blood Pressure	Y / N	Tuberculosis	Y / N	Hospitalization/Surg.
Y / N	AIDS/HIV	Y / N	Arthritis	Y / N	Thyroid Disease	Y / N	Bleeding Disorder
Y / N	Frequent Colds	Y / N	Major Illness	Y / N	Birth Defect	Y / N	Order

If you answered YES to any of the above, please explain:______________________

____

Are you taking any medications? Y / N What?______________________

Do you have any allergies (i.e. Penicillin, Aspirin, Food, Metals)? Y / N What?______________________

WOMEN: Are you pregnant? Y / N What trimester?______________________

GENERAL INFORMATION

Has the patient reached (Menstruation) Puberty? Y / N When?______________________

Does the patient have any relatives with a similar bite? Y / N Which relative?______________________

Other relatives being treated here:______________________

Who were you referred by?______________________

ORAL HEALTH HISTORY

Dentist:______________________ Phone:______________ Last Visit:__________

Address:______________________ City:______________ State:______ Zip:________

Why are you seeking treatment?______________________

Do you consider treatment in this case to be mainly for: Health Cosmetics Psychological Other______________

What would you like treatment to accomplish?______________________

____

IS THERE ANY HISTORY OF: (PLEASE CIRCLE)

Y / N	Clicking of jaw/joints	Y / N	Tongue thrusting/habit	Y / N	Prior Orthodontic Treatment
Y / N	Pain in jaw joints (ear)	Y / N	Grinding teeth (day/night)	Y / N	Extra teeth
Y / N	Injuries to the teeth	Y / N	Pen, lip or nail biting	Y / N	Extraction of teeth
Y / N	Injuries to the face	Y / N	Thumb/finger sucking	Y / N	Missing teeth
Y / N	Difficulty chewing	Y / N	Chewing gum	Y / N	Speech problem
Y / N	Fever blisters/ulcers	Y / N	Mouth Breathing	Y / N	Dry mouth

If you answered YES to any of the above, please explain:______________________

____

To the best of my knowledge, all the preceding answers are true and correct. I authorize Dr. Spielberg and staff to perform any necessary dental procedures and treatments on ______________________(patient).

Patient / Parent / Guardian Signature______________________ **Date:**______________