



Going the Extra Mile for a Perfect Smile

Oleg E. Eisenstein, DMD

*Orthodontics
Dentofacial Orthopedics*

Patient Information

_____	_____	_____	_____
Last Name	First Name	MI	Preferred Name
_____	_____	_____	_____
Date of Birth	Social Security #	Gender	Marital Status

Street Address			
_____	_____	_____	_____
City	State	Zip Code	e-mail
_____	_____	_____	_____
Home Phone #	Work Phone #	Cell Phone #	
_____		_____	
Employer / School		Position / Grade	

Welcome to our practice!
Please fill out the information
below and return to our New
Patient Coordinator.
THANK YOU!!!

Whom may we thank for referring you to our practice? Please circle your selection:

Another Patient Dentist Office Yellow Pages Television Radio Magazine / Newspaper Direct Mail Billboard /Office Sign Website / Internet Other

Please indicate the name of person, organization, or publication referring you to our practice: _____.

Responsible Party Information

_____	_____	_____
Last Name	First Name	MI
_____	_____	_____
Date of Birth	Social Security #	Relationship to the Patient

Street Address		
_____	_____	_____
City	State	Zip Code
_____	_____	_____
Home Phone #	Work Phone #	Cell Phone #
_____	_____	_____
Employer	Position	

Orthodontic Insurance Policy Holder Information

_____	_____	_____
Last Name	First Name	MI
_____	_____	_____
Date of Birth	Social Security # or Employee ID	Relationship to the Patient

Street Address		
_____	_____	_____
City	State	Zip Code
_____	_____	_____
Ins. Company Name	Ins. Company Phone #	Subscriber ID
_____	_____	_____
Employer	Position	

Information and Payment Authorization Release:

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNATURE OF RESPONSIBLE PARTY

DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO **OLEG EISENSTEIN DMD, PC dba EISENSTEIN ORTHODONTICS** OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME

SIGNATURE OF INSURED PERSON

DATE

Child Care Release:

I am aware that Eisenstein Orthodontics cannot and will not assume any responsibility for the care of any patient left unattended prior to and/or after their treatment visit has been completed. In addition, Eisenstein Orthodontics will not undertake to monitor the behavior of or care for small children left unattended in the waiting room while their parents are back in the treatment area.

Signature of Responsible Party

Date

295 Molly Lane, Suite 140 • Woodstock, Georgia 30189 • Tel: 770.928.9227
1771 Lee Road, Suite A • Lithia Springs, Georgia 30122 • Tel: 770.739.1111

www.eisensteinorthodontics.com



Going the Extra Mile for a Perfect Smile

Oleg E. Eisenstein, DMD

*Orthodontics
Dentofacial Orthopedics*

Patient's Name: _____

_____ Last, _____ First _____ MI
Patient's Date of Birth: _____ Please Circle: male female

Patient / Parent's Chief Concern _____

or Reason for this consultation _____

Is patient currently under dentist's care? Yes No

Dentist's Name: _____

Dentist's Phone #: _____

Date of last dental exam: _____

Findings of last dental exam: _____

Past history of routine dental visits? Yes No

Normal frequency: _____

History of prior orthodontic treatment? Yes No

If YES, how long ago? _____

How often does patient brush? _____ floss? _____

Has patient ever had any complications following dental Treatment? Yes No

If YES, please explain: _____

Is patient presently under the care of a physician? Yes No

Dr's Name: _____

Dr's Phone #: _____

Conditions Treated: _____

Date of last medical exam: _____

Findings of last exam: _____

<i>Now or in the past, has the patient had:</i>	Yes	No	Not Sure
Allergies: Drugs / Materials			
Asthma / Hay Fever			
Bacterial Endocarditis			
Birth Defects / Hereditary Problems			
Blood / Bleeding Problems			
Bone Fractures / Major Accidents			
Breathing / Respiratory Problems			
Cancer / Tumor / Radiation Treatment / Chemotherapy			
Cardiovascular Problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defect, heart murmur, rheumatic fever, rheumatic heart disease)			
Diabetes			
Eating Disorder (anorexia, bulimia)			
Endocrine or Thyroid Problems			
Epilepsy / Seizure Disorders			
Fainting / Dizziness			
Gastrointestinal Problems			
Headaches / Neckaches			
Hepatitis / Jaundice / Liver Problems			
High or Low Blood Pressure			
HIV / AIDS			
Immuno-Suppressed / Compromised			
Infectious Diseases			
Jaw Pain / Clicks / Bruxism / Trismus			
Joint Replacement			
Kidney Problems			
Learning Disorder			
Mitral Valve Prolapse			
Obstructive Sleep Apnea / Snoring			
Osteoporosis			
Premedication prior to dental treatment			
Polio / Mononucleosis / Tuberculosis / Pneumonia			
Rheumatoid or Arthritic Condition			
Skin Disorder			
Speech / Hearing Disorder			
Sore Throats / Chronic Strep			
Tonsils or Adenoids Problems			
Tonsillectomy <input type="checkbox"/> or Adenoidectomy <input type="checkbox"/>			

Has patient experienced onset of puberty?			
Has pubertal growth ceased?			
Is continued growth expected?			
Does patient follow the directions well?			
Does patient participate in contact sports?			
Does patient wear mouthguard?			
Family history of orthodontic treatment?			
Was family member treatment successful?			

Females only:

Has patient started her monthly periods?			
If so, approximately when? _____			
Is the patient pregnant?			
If so, when is a due date? _____			
Is patient anticipating becoming pregnant?			
Is patient taking birth control medication?			
If so, which one? _____			

	Yes	No	Not Sure
Does patient currently or has the patient ever had a substance abuse problem?			
Does patient chew or smoke tobacco?			
Is patient currently or has patient ever taken any intravenous bisphosphonates for serious bone disorders / cancers: such as Zometa (zoledronic acid), Aredia (pamidronate), Didronel (etidronate)?			
Is patient currently or has patient ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didrunel (elidronate)?			
Is patient currently or taking medications, nutrient supplements, herbal medications or non-prescription medicine? If Yes, please name them below.			

Medication	Dose	Taken for

Patient Habits:

	Yes	No	Not Sure
Reverse Swallow / Tongue Thrust			
Lip Biting / Wedging			
Thumb Sucking			
Finger Sucking			
Nail Biting			
Object Chewing (pen, pencil, etc)			
Mouth Breathing			
Bruxing / Clenching			
Musical Instruments			
If so, select (circle): Horn Reed Violin			

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

Name of patient, parent or guardian _____ Relationship to patient _____ Signature _____ Date _____

295 Molly Lane, Suite 140 • Woodstock, Georgia 30189 • Tel: 770.928.9227
1771 Lee Road, Suite A • Lithia Springs, Georgia 30122 • Tel: 770.739.1111

www.eisensteinorthodontics.com