Oleg E. Eisenstein, DMD

Orthodontics
Dentofacial Orthopedics

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

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

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 e-mail

_______________ _______________ _______________
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 Phone #

_______________ _______________ _______________
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 ________________________________

Now or in the past, has the patient had:	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 [ ] or Adenoidectomy [ ]			

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? ________________			

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: ________________________________

	Yes	No	Not Sure
Does patient currently or has the patient ever had a substance abuse problem?			
Does patient chew or smoke tabacco?			
Is patient currently or has patient ever taken any intravenous bisphosphonates for serious bone disorders / cancers: such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?			
Is patient currently or has patient ever taken any oral bisphosphanates for osteoporosis, osteopenia or other uses: such as Fosamax (alendronate), Actonel (risendromate), 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

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