Dr. Lisa Eckenstein, D.D.S., M.S., Ltd., P.C.
16624 South 107th Court, Unit B
Orland Park, Illinois 60467
708-460-7556

PATIENT INFORMATION

Patient Name Last First Middle Initial		Nickname
Gender ☐ Male ☐ Female	Birth Date Month Day Year	Current Age
Home Address Street City State Zip		
Home Phone Email		
School Attending		Current School Age
Father's Name ((Dr. Mr.)	Occupation	Work Phone
Mother's Name (Dr. Mrs. Ms Miss)	Occupation	Work Phone
Sibling's Names		Birth Date Month Day Year
Relationship ☐ Father ☐ Mother ☐ Guardian		
Insured Name Last First Middle Initial		SS# Birth Date
Insured Employer		Employer Phone
Primary Dental Ins. Co.		Group Number:
Dental Ins. Co. Address Street City State Zip		Dental Ins. Co Phone
Patient's Dentist Patient's Dentist		Dentist Phone

Has patient had previous orthodontic consultation? ❑ Yes ❑ No

Has the patient received previous orthodontic treatment? ❑ Yes ❑ No

Who prompted the consultation? _____

Has patient had any unusual dental experience? ❑ Yes ❑ No

If yes, please specify _____

Have there been any injuries to the face, mouth, or teeth? ❑ Yes ❑ No

If yes, please specify _____

Has the patient been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has the patient ever been treated for (check all that apply)

❑ bad bite ❑ periodontic disease ❑ TMJ ❑ none

If so by whom _____

Does the patient have pain or clicking in jaw joint? ❑ Yes ❑ No

Has the patient received or requested to receive speech therapy? ❑ Yes ❑ No

Does the patient have any of the following habits (check all that apply)

❑ teeth grinding ❑ lip biting or sucking ❑ thumb sucking, until age _____

❑ mouth breathing ❑ tongue thrusting ❑ finger sucking until age _____

❑ snoring ❑ other habits _____

Does the patient (check all that apply)

❑ have difficulty chewing or swallowing?

❑ have frequent "stuffy nose"?

❑ have allergies (please specify)_____

Has the patient ever had (check all that apply)

❑ anemia	❑ diabetes	❑ head or face injury	❑ herpes
❑ asthma	❑ endocrine problems	❑ hearing disorder	❑ HIV/AIDS
❑ blood disease	❑ emotional problems	❑ heart disease	❑ rheumatic fever
❑ bone disorder	❑ epilepsy	❑ hepatitis	❑ scarlet fever

❑ Other (please specify) _____

Has the patient received treatment from an allergist or ear, nose and throat doctor? ❑ Yes ❑ No

If yes, by whom?_____ and when? _____

Has the patient received and additional physician's care during the past two years other than routine examination? ❑ Yes ❑ No

If yes please specify _____

Is the patient currently taking any prescription drug or over the counter medication? ❑ Yes ❑ No

If yes, please specify _____

I, the undersigned, hereby certify that the above information is accurate and complete to the best of my knowledge. This office will not be responsible for any problems arising out of inadequate information not disclosed.

Signature of Patient: _____ Date: _____

(if patient is a minor, parent or legal guardian must sign)