

# NORD



## ORTHODONTICS

We are pleased to welcome you to our office. We hope you will find a kind and comfortable atmosphere here. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help. We look forward to having you here as a patient!

### PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ M F  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
**Previous Address (if less than 3 years)** \_\_\_\_\_  
 \_\_\_\_\_  
 Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 Cell # \_\_\_\_\_ SSN # \_\_\_\_\_  
 Email \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Job Title \_\_\_\_\_ No. yrs. Employed \_\_\_\_  
 Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_  
 Favorite Sports or Hobbies \_\_\_\_\_  
 Other \_\_\_\_\_  
 In Case of Emergency Contact \_\_\_\_\_  
 Phone # \_\_\_\_\_ Relation \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_  
 Insured Name \_\_\_\_\_  
 Contact # \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Employer \_\_\_\_\_  
 Coverage Amount \_\_\_\_\_ % up to \_\_\_\_\_ max. \_\_\_\_\_ ded.  
 Secondary Insurance Name \_\_\_\_\_  
 Insured Name \_\_\_\_\_  
 Contact # \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Employer \_\_\_\_\_  
 Coverage Amount \_\_\_\_\_ % up to \_\_\_\_\_ max. \_\_\_\_\_ ded.  
 Third Insurance Name \_\_\_\_\_  
 Insured Name \_\_\_\_\_  
 Contact # \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Employer \_\_\_\_\_  
 Coverage Amount \_\_\_\_\_ % up to \_\_\_\_\_ max. \_\_\_\_\_ ded.

### REFERRAL

Who referred you to our office?  
 Dentist \_\_\_\_\_  
 Friend \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Phone Book \_\_\_\_\_  
 Other \_\_\_\_\_

### SPOUSE'S INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 SSN \_\_\_\_\_ Cell # \_\_\_\_\_  
 Employer \_\_\_\_\_ Job Title \_\_\_\_\_  
 Email \_\_\_\_\_

### PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT

Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 Employer \_\_\_\_\_ Job Title \_\_\_\_\_  
 No. years employed \_\_\_\_\_ SSN \_\_\_\_\_

Orthodontics for kids of all ages!

Member  
 American Association of  
**Orthodontists**



**Please complete the dental and medical history on the back of this page. Thank you!**

**DENTAL AND ORTHODONTIC HISTORY**

In your words, what is the orthodontic problem? \_\_\_\_\_

Have you had any previous orthodontic treatment or consultation?    yes    no

If so, what was completed, and by whom? \_\_\_\_\_

Has any other family had orthodontics? \_\_\_\_\_

If so, what work was completed and by whom? \_\_\_\_\_

Were the results acceptable? Yes    No

Do you now have or have you experienced pain or discomfort in your jaw joint? Yes    No

Do you grind your teeth? Yes    No

Do you have any speech problems/tongue thrust? Yes    No

Do you have or have you ever had any thumb or finger sucking habits? Yes    No

Do you usually breath through your mouth while awake? Yes    No

Have you ever experienced an adverse reaction during a medical or dental procedure? Yes    No

Have you ever received serious trauma or injury to the teeth, face, jaws or head? Yes    No

Do you have a family history of jaw size imbalance or missing, impacted, malformed or extra teeth? Yes    No

Have you been treated for or diagnosed with any periodontal problems? Yes    No

If yes to any of the above, please explain: \_\_\_\_\_

Please best describe the patient's attitude toward orthodontic treatment:

Wants treatment    Treatment is necessary    Unwilling, but agrees    Uncooperative

**MEDICAL HISTORY**

Please check if you have a history of any of the following:

Yes    No

Yes    No

AIDS/HIV

Allergies (latex, codeine, penicillin, metals, anesthetics, other)

Artificial Joints or Valves

Asthma or Hay fever

Blood Pressure Problems

Cancer, tumor, radiation treatment or chemotherapy

Convulsions, Epilepsy or Fainting Spells

Diabetes

Difficulty Breathing

Endocrine, Thyroid or Growth Problems

Excessive bleeding, anemia or bleeding disorder

Heart Disease or Conditions

Heart Murmur

Headaches

Hepatitis

Mitral Valve Prolapse

Osteoporosis/Osteopenia

Rheumatic/Scarlet Fever

Rheumatoid or Arthritic Conditions

Tonsillitis

Tuberculosis

If you answered yes to any of the above, please explain in more detail: \_\_\_\_\_

Are you under the care of a physician for a specific condition not listed above?    Yes    No

If yes, please describe: \_\_\_\_\_

Are you pregnant or do you anticipate becoming pregnant?    Yes    No

Are you taking any medications? (including bisphosphonates, anti-inflammatories and steroids)    Yes    No

If yes, please list medication and what it's taken for: \_\_\_\_\_

**AUTHORIZATION**

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. I also understand that if there is any change to my, or the above named patient's dental or medical status, it is my responsibility to inform the doctor. I also understand that where appropriate, credit bureau reports will be obtained.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_