

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 Phone _____ Cell Phone _____
 Dentist _____ Last Visit _____
 Favorite Sports or Hobbies _____
 School _____ Grade _____
 Parent or Legal Guardian _____
 Patient's Residence: Both Parents Mother Father
 In Case of Emergency Contact _____
 Email: _____

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.

Orthodontics for kids of all ages!

REFERRAL

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

FAMILY INFORMATION

Mother's Information Mom Step mom Guardian
 Name _____ Birthdate ____/____/____
 Address _____
 City _____ State _____ Zip _____
 Home # _____ Work # _____
 SSN _____ Cell # _____
 Employer _____ Job Title _____
 Email _____

Father's Information Dad Step dad Guardian
 Name _____ Birthdate ____/____/____
 Address _____
 City _____ State _____ Zip _____
 Home # _____ Work # _____
 SSN _____ Cell # _____
 Employer _____ Job Title _____
 Years at current job _____
 Email _____

Siblings (names and ages) _____

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT

Name _____ Relation _____
 Address _____
 Home # _____ Work # _____

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

Menstruation/PMS started _____ (date)

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 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: _____