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 _____

Own ☐_____ yrs Rent ☐_____ yrs

Previous Address (if less than 3 years) _____

_____

Home Phone _____Cell Phone_____

Email: _____

Dentist _____ Last Visit _____

Favorite Sports or Hobbies _____

School _____ Grade _____

Parent or Legal Guardian _____

Patient's Residence: ☐Both Parents ☐Mother ☐Father

Emergency Contact _____Phone _____

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 # _____

Cell # _____ Cell Provider _____

SSN _____

Employer _____ Job Title _____

Email _____

Father's Information ☐Dad ☐Step dad ☐Guardian

Name _____ Birthdate ____/_____/_____

Address _____

City _____ State _____ Zip _____

Home # _____Work # _____

Cell #_____ Cell Provider_____

SSN # _____

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 member 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	
Yes	No	AIDS/HIV	Yes	No	Heart Disease or Conditions
Yes	No	Allergies (latex, codeine, penicillin, metals, anesthetics, other)	Yes	No	Heart Murmur
Yes	No	Artificial Joints or Valves	Yes	No	Headaches
Yes	No	Asthma or Hay fever	Yes	No	Hepatitis
Yes	No	Blood Pressure Problems	Yes	No	Menstruation/PMS started_____(date)
Yes	No	Cancer, tumor, radiation treatment or chemotherapy	Yes	No	Mitral Valve Prolapse
Yes	No	Convulsions, Epilepsy or Fainting Spells	Yes	No	Osteoporosis/Osteopenia
Yes	No	Diabetes	Yes	No	Rheumatic/Scarlet Fever
Yes	No	Difficulty Breathing	Yes	No	Rheumatoid or Arthritic Conditions
Yes	No	Endocrine, Thyroid or Growth Problems	Yes	No	Tonsillitis
Yes	No	Excessive bleeding, anemia or bleeding disorder	Yes	No	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 bisphosponates, 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: _____