

# NELSON ORTHODONTICS

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## Patient/Parent Information

Patient's Name \_\_\_\_\_

Prefers to be called \_\_\_\_\_

Patient Sex  M  F

### Address

Street / City / State / Zip \_\_\_\_\_

Patient Birth date \_\_\_\_\_ Age \_\_\_\_\_

### Contacts

Email address: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

If a minor, who does the patient live with? \_\_\_\_\_ School \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

*Please fill out below if patient is a minor*

### Parent/ Guardian Information

First / Middle / Last \_\_\_\_\_

SSN # \_\_\_\_\_ Birth date \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Street / City / State / Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years employed \_\_\_\_\_

Insured's First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years employed \_\_\_\_\_

Do you have dual coverage? Yes  No

Secondary Insured's First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years employed \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_ Home phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**OVER----->**

### Dental Insurance Information

### Secondary Insured's Information

### Emergency Information

\_\_\_\_\_  
 Patient's Name

Child Habits

**If patient is a child, does/did your child have any of the following habits?**

Clenching/grinding teeth	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nursing bottle habits	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lip sucking/biting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Speech impediments	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mouth breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thumb/finger sucking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nail biting	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

General Dentist

\_\_\_\_\_  
 Name Date of last visit

\_\_\_\_\_  
 City State Zip

Family Physician

\_\_\_\_\_  
 Name Date of last visit

Are you under the care of a physician? Yes  No   
 Please explain: \_\_\_\_\_

Are you taking any prescription/over-the-counter drugs? Yes  No   
 Please explain: \_\_\_\_\_

Do you require antibiotic pre-medication prior to dental work/cleanings? Yes  No

Medical  
 Conditions

**Have you ever had any of the following diseases/medical conditions?**

Abnormal bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing Impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies to drugs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hemophilia/Abnormal bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy/Seizures/Fainting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Periodontal Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fever blisters/Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Handicaps/Disabilities	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please list any serious medical conditions you have had: \_\_\_\_\_

Please list any drug/substances that you are allergic to: \_\_\_\_\_

If female, is there any possibility you are pregnant? Yes  No  Trimester \_\_\_\_\_

**If the patient is an adolescent, please answer the following:**

Height: \_\_\_\_\_ Recent growth? Yes  No  How much? \_\_\_\_\_ Weight \_\_\_\_\_

Boys: Has his voice changed? Yes  No  Girls: Has she begun menstruation? Yes  No

What are the main concerns that you would like orthodontics to address?  
 \_\_\_\_\_  
 \_\_\_\_\_

Please Explain

Have you ever had or been evaluated for orthodontic treatment? Yes  No

If yes when? \_\_\_\_\_

Have you ever had a serious/difficult problem associated with any previous dental work? Yes  No

Please Explain: \_\_\_\_\_

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) Yes  No

You current physical health is: Good  Fair  Poor

Do you like to smile? Yes  No  Do your gums ever bleed? Yes  No

Have you ever had an injury to your: Mouth  Teeth  Chin

Do you have/have you ever had any speech impediments? Yes  No

If yes, please list: \_\_\_\_\_

Do you generally breathe through your mouth while you sleep? Yes  No

Do you know if you have any missing/extra permanent teeth? Yes  No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

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

Please Check