NELSON ORTHODONTICS
206 784 5372 fx 206 784 6389 7556 15TH AVE NW SEATTLE 98117

Patient/Parent Information

_____
Patient's Name

Prefers to be called _____

Patient Sex M F

Patient's Birthdate: _____ Age: _____

Home Address: _____

Home Phone: _____

If a minor – Mother's Name: _____ Father's Name: _____ Marital Status M S D W

Who referred you to our office? _____ What is your main concern? _____

Who does patient live with: _____ Who are the other family members we have treated? _____

Responsible Party Information #1

Name: _____

Address _____ Years at address _____

Email Address _____ Home Phone _____ Work Phone _____

Cell Phone _____ Social Security #: _____ Employer _____

Occupation _____ Years employed _____ Date of Birth _____

Responsible Party Information #2

Name: _____ Phone _____

Address _____

Email Address _____ Home Phone _____ Work Phone _____

Cell Phone _____ Social Security # _____ Employer _____

Occupation _____ Years employed _____ Date of Birth _____

PRIMARY DENTAL (NOT MEDICAL) INSURANCE INFORMATION SO WE CAN CHECK ORTHODONTIC BENEFITS

Insured's Name _____ Date of Birth _____

Insurance Company Name _____ Phone Number of Ins. Company _____

Social Security or ID Number _____ Group Number _____

Group Name _____ Do you have dual coverage? Yes ☐ No ☐

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____

Insurance Company Name _____ Phone Number _____

Social Security or ID Number _____ Group Number _____

Group Name _____

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Patient Care Information

_____ Patient's Name

Child Habits

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

Clenching/grinding teeth- Past __ Present __
Thumb/finger sucking Past __ Present __
Nail biting Past __ Present __

General Dentist

Name _____ Date of last visit _____

_____

City State Zip

Are you under the care of a physician other than well check visits? Yes ☐ No ☐
If so 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 ☐	No ☐	Hearing Impairment	Yes ☐	No ☐
Allergies to drugs	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Hemophilia/Abnormal bleeding	Yes ☐	No ☐
Difficulty breathing	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Epilepsy/Seizures/Fainting	Yes ☐	No ☐	Periodontal Disease	Yes ☐	No ☐
Fever blisters/Herpes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Handicaps/Disabilities	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐

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 ☐

Have you ever had or been evaluated for orthodontic treatment? Yes ☐ No ☐
If yes when? _____

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. I understand that where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____