ND ORTHODONTICS

CONFIDENTIAL: Child/Adolescent

Patient Information

Date:_____

Patient's name:_____
Last First Middle

Address:_____
Street City State Zip

Age:__ Sex:____ Height:_____ Weight:_____ Birthdate:_____

School:_____ Grade:_____ Sports/Hobbies:_____

Father's Name_____

Address:_____
Street City State Zip

Previous Address (if less than 3 years): _____
Street City State Zip

Home #:_____ Work #:_____ Cell #:_____ Email:_____

Social Security #:_____ Employer:_____

Occupation:_____ # of Years Employed:_____

Mother's Name_____

Address:_____
Street City State Zip

Previous Address (if less than 3 years): _____
Street City State Zip

Home #:_____ Work #:_____ Cell #:_____ Email:_____

Social Security #:_____ Employer:_____

Occupation:_____ # of Years Employed:_____

Person(s) assuming financial responsibility:_____

Name and ages of children in family:_____

Other family members treated here?_____

Who suggested that you might need orthodontic treatment?_____

Whom may we thank for referring you to our office?_____

Insurance Information

Primary Insurance Information

Insured's Name:_____ Insured's Social Security #:_____

Insurance Company:_____ Group #:_____ Subscriber #:_____

Insurance Co. Address:_____ Phone:_____

Insured's Employer:_____ Insured's DOB:_____

Relationship to Patient:_____

Home #:_____ Work #:_____ Cell #:_____ Email:_____

Secondary Insurance Information

Insured's Name:_____ Insured's Social Security #:_____

Insurance Company:_____ Group #:_____ Subscriber #:_____

Insurance Co. Address:_____ Phone:_____

Insured's Employer:_____ Insured's DOB:_____

Relationship to Patient:_____

Home #:_____ Work #:_____ Cell #:_____ Email:_____

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Emergency Information

Person to contact in case of emergency:_____
Home #:_____ Work #:_____ Cell #: _____

Medical History

Medical Contact

Physician:_____ Phone:_____
Address:_____
Street City State Zip

Medical History

Y N Are you in good health? Your last physical exam was_____(month/year)
Y N Are you now under the care of a physician? If so, what is being treated?_____
Y N Have you had a serious illness/hospitalization in the past 5 years? If so, explain:_____
Y N Are you taking any medication? (if yes, please describe): _____

Please indicate if you are allergic or have reacted adversely to:

Y N Latex
Y N Penicillin or other antibiotics
Y N Sulfa Drugs
Y N Aspirin, Ibuprofen, Tylenol
Y N Local Anesthetics
Y N Codeine or other narcotics
Y N Vinyl
Y N Acrylic
Y N Metals (jewelry, clothing snaps)
Y N Other_____

Girls Only:

Y N Have you started monthly periods?
Y N Are you pregnant?

Please indicate if you have experienced any of the following conditions:

Y	N	Low blood pressure	Y	N	Fainting spells or seizures
Y	N	High blood pressure	Y	N	Epilepsy or other neurological disorder
Y	N	Cardiovascular disease	Y	N	Blood disorder such as anemia
Y	N	Rheumatic fever	Y	N	Eye, ear, nose or throat condition
Y	N	Heart murmur	Y	N	Tire easily
Y	N	Arthritis or joint problems	Y	N	Problems of the immune system
Y	N	Respiratory problems, emphysema	Y	N	Birth Defects
Y	N	Asthma or hay fever	Y	N	Kidney trouble
Y	N	Sinus trouble	Y	N	Tuberculosis, polio, mononucleosis
Y	N	Persistent swollen neck gland	Y	N	Bone fractures or trauma to face or jaw
Y	N	Thyroid or endocrine problems	Y	N	Vision, hearing or speech difficulty
Y	N	Diabetes	Y	N	Persistent cough
Y	N	Hepatitis, jaundice or liver disease	Y	N	Frequent colds or sore throats
Y	N	AIDS or HIV infection	Y	N	Frequent headaches
Y	N	Sexually transmitted disease	Y	N	Stomach ulcer or hyperacidity
Y	N	Substance abuse problem (past or present)	Y	N	Tumor (cancerous or benign)
Y	N	Chew or smoke tobacco (past or present)	Y	N	Radiation therapy or chemotherapy
Y	N	Mental health problem or nervous disorder	Y	N	Tonsils/adenoids removed? What age:____
Y	N	Abnormal bleeding or blood transfusion	Y	N	Loss of weight recently, poor appetite
Y	N	History of eating disorder (anorexia, bulimia)	Y	N	Skin disorder

Y N Do you have any disease, condition or problem not listed above that you think we should know about? If so, please explain:_____

NAHAL DARVISH DMD, PLLC (MMSc, MSEd) | www.ndorthodontics.com | info@ndorthodontics.com
Suite 102 • 16708 Bothell-Everett Hwy. • Mill Creek, WA 98012 | T: 425-379-6200 | F: 425-379-6226

ND ORTHODONTICS

Dental History

General Dentist:_____ Phone:_____
Address:_____
Street City State Zip
Date of last dental exam:_____ Reason for last dental exam:_____
Reason for your consultation today:_____

Y	N	Previous orthodontic exam, treatment, or retainer	Y	N	Teeth sensitive to hot or cold
Y	N	Mouth breathing habit or snoring troubles	Y	N	Loose or shifting teeth
Y	N	Abnormal swallowing (tongue thrust)	Y	N	Periodontal (gum) problems
Y	N	Frequent canker sores or cold sores	Y	N	Bleeding gums or bad mouth odor
Y	N	Thumb or finger habit as a child? Age_____	Y	N	Jaw fracture/cyst/mouth infections
Y	N	Would you wear orthodontic appliances (braces) if indicated?	Y	N	Anxiety about dental visits?
Y	N	Problems with food trapped between teeth			

TMJ History

Y	N	Have you had a TMJ screening?	Y	N	Do you have pain in your jaw joint?
Y	N	Do you have a history of jaw joint problems?	Y	N	Do you grind your teeth?
Y	N	Do you clench your teeth?	Y	N	Have you been treated for "TMJ"?
Y	N	Soreness in facial muscles or around ears?	Y	N	Has your jaw ever locked?
Y	N	Does your bite feel uncomfortable?	Y	N	Do you have clicking or popping?
Y	N	Do you have difficulty chewing or opening your mouth?			

Patient Motivation For Orthodontic Treatment

Patients and their general dentists often request changes in bites and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (circle the words more, less, forward, etc.)

Teeth – If your teeth could be changed, how would you like them to change?

- ☐ Straighten the front teeth – **upper / lower**
- ☐ Straighten the back teeth – **upper/lower**
- ☐ Move upper teeth – **forward / backward**
- ☐ Move lower teeth – **forward / backward**
- ☐ Eliminate crowding of teeth – **upper / lower**
- ☐ Eliminate spaces between teeth – **upper / lower**
- ☐ Make the line of upper teeth more level
- ☐ Other_____

Face – If your facial appearance could be changed, what would you change?

- ☐ Move upper lip – **forward / backward**
- ☐ Move lower lip – **forward / backward**
- ☐ Show – **more / less** – of teeth when smiling
- ☐ Show – **more / less** – of gums when smiling
- ☐ Reduce the strain in – **chin / lips** – when lips close
- ☐ Make lips – **closer together / farther apart** – when teeth are touching
- ☐ Make profile of nose – **longer / shorter**
- ☐ Get rid of sag under lower jaw
- ☐ Move chin – **forward / backward**
- ☐ Move chin – **left / right**
- ☐ Other_____

I hereby acknowledge that I have read and understood the above questions and that the information that I provided is accurate to the best of my knowledge. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I further consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes. If there are any changes later to this history record or medical/dental status, I will so inform this practice. I understand that where appropriate, credit bureau reports may be obtained.

_____
Signature of Parent Date

_____ _____
Update Signature Date Update Signature Date

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