Nichols Orthodontics, Inc.

orthodontics for children & adults
Laura Nichols, DDS, MS

PATIENT INFORMATION

First Name: _____ Last Name: _____ Nickname: _____

☐ Male ☐ Female Birth date: _____/_____/_____ Social Security #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Single ☐ Separated
☐ Married ☐ Divorced Cell Phone: _____ Appointments should be confirmed by: ☐ Text Cell ☐ Call Cell ☐ Email

Dentist: _____ Last Dental Visit: _____/_____/_____ Person Financially Responsible: _____

Who may we thank for referring you to our office? _____ Related patients in our care: _____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

☐ Patient Responsible

Legal First & Last Name: _____ Birth date: _____/_____/_____

Same address as patient? ☐ YES ☐ NO Email: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Employer: _____ Work Phone: _____

DENTAL INSURANCE

Do you have orthodontic benefits? ☐ Yes ☐ No ☐ Unsure

Insured First & Last Name: _____ Relation: _____ Birth date: _____/_____/_____

Social Security #: _____ Employer: _____ Plan Name: _____

Insurance Company: _____ ID #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

First & Last Name: _____

Relationship : _____ Cell Phone: _____ Work Phone: _____

I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance and my account.
I understand that I can withdraw my consent at any time. Initial _____

I consent to receiving from the dental practice email communications regarding treatment, insurance and my account.
I understand that I can withdraw my consent at any time. Initial _____

MEDICAL HISTORY

Physicians Name:_____ Office Phone: _____

Are you currently experiencing any health problems? ☐ YES ☐ NO If yes please explain: _____

Are you currently taking any medications? ☐ YES ☐ NO List: _____

Are you allergic to any medications? ☐ YES ☐ NO List: _____

Have you had your tonsils or adenoids been removed? ☐ YES ☐ NO

For women: Are you currently taking birth control pills? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Week #: _____

Are you nursing? ☐ YES ☐ NO

Please check if you have had any of the following conditions:

☐ Allergies	☐ Cancer	☐ Epilepsy	☐ Heart Surgery	☐ Rheumatic Fever
☐ Allergy to Latex	☐ Developmental Disorder	☐ Fainting	☐ HIV Positive	☐ Sleep Apnea
☐ Asthma	☐ Diabetes	☐ Growth Disorders	☐ Kidney Disease	☐ Smoking
☐ Blood Disease	☐ Emotional Disorder	☐ Heart Murmur	☐ Liver Disease	☐ Tuberculosis
☐ Bone Disorder	☐ Endocrine Disorder	☐ Hepatitis	☐ Mouth Breathing	☐ Have you ever taken bisphosphonate (Fosamax)

Any other conditions or problems: _____

DENTAL HISTORY

Is there any unfinished dental care? ☐ YES ☐ NO

Are you apprehensive about dental treatment? ☐ YES ☐ NO

Have you had previous orthodontic treatment? ☐ YES ☐ NO

Have you ever had injuries to mouth, teeth or chin? ☐ YES ☐ NO

Have you been informed of any missing or extra permanent teeth? ☐ YES ☐ NO

Do you like your smile? ☐ YES ☐ NO

Please check if the you have/had any of the following conditions:

☐ Clenching	☐ Headache	☐ Jaw Joint Popping/Clicking	☐ Ringing in the Ears
☐ Grinding Teeth	☐ Jaw Joint Soreness	☐ Musclar soreness around head and neck	☐ Speech Problems

What are the main concerns that you would like orthodontics to accomplish?

_____

Is there any other information that may be helpful?

_____

_____

I understand that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence per HIPPA regulations. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Patient Signature:_____ Date:_____

ACCEPTANCE OF TREATMENT DURING COVID-19 OUTBREAK

As with the transmission of any communicable disease like a cold or flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment? ☐ YES ☐ NO

Paitient Signature:_____ Date:_____