Nichols Orthodontics, Inc.

orthodontics for children & adults

Laura Nichols, DDS, MS

PATIENT INFORMATION

First Name: _____ Last Name: _____ Preferred Name: _____

Gender Assigned at Birth: ☐ Male ☐ Female Pronoun: ☐ he/his ☐ she/her ☐ they/them

Birth date: _____/_____/_____ Age: _____ School: _____ Grade: _____

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

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

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

If parents are divorced, who is the custodial parent? _____ ☐ N/A

May patient information be released to the noncustodial parent? ☐ Yes ☐ No ☐ N/A

PARENT INFORMATION

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

Same address as patient? ☐ YES ☐ NO

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

Appointments should be confirmed by: ☐ Text Cell ☐ Call Cell ☐ Email Email: _____

Cell Phone: _____ Home Phone: _____

PARENT INFORMATION

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

Same address as patient? ☐ YES ☐ NO

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

Appointments should be confirmed by: ☐ Text Cell ☐ Call Cell ☐ Email Email: _____

Cell Phone: _____ Home 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: _____

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: _____

Is the patient currently experiencing any health problems? ☐ YES ☐ NO If yes please explain: _____

Is the patient currently taking any medications? ☐ YES ☐ NO List: _____

Is the patient allergic to any medications? ☐ YES ☐ NO List: _____

Have the patient's tonsils or adenoids been removed? ☐ YES ☐ NO

Please check if the patient has/had any of the following conditions:

☐ Allergies	☐ Cancer	☐ Epilepsy	☐ Heart Surgery	☐ Rheumatic Fever
☐ Allergy to Latex	☐ Developmental Disorder	☐ Fainting	☐ HIV Positive	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Growth Disorders	☐ Kidney Disease	Any other conditions or problems: _____
☐ Blood Disease	☐ Emotional Disorder	☐ Heart Murmur	☐ Liver Disease	_____
☐ Bone Disorder	☐ Endocrine Disorder	☐ Hepatitis	☐ Mouth Breathing	_____

INFORMATION FOR PATIENTS UNDER 18 YEAR OF AGE

Is the patient adopted? ☐ YES ☐ NO

Has your child reached puberty? ☐ YES ☐ NO

AFAB: Started Menstruation? ☐ YES ☐ NO Age:_____

AMAB: Voice Change? ☐ YES ☐ NO

Do you feel growth is completed? ☐ YES ☐ NO

Patient Height: _____

Father Height: _____

Mother Height: _____

DENTAL HISTORY

Does (did) your child have a finger sucking habit? ☐ YES ☐ NO

Is there any unfinished dental care? (sealants or fillings) ☐ YES ☐ NO

Is the patient apprehensive about dental treatment? ☐ YES ☐ NO

Has the patient had previous orthodontic treatment? ☐ YES ☐ NO

Have siblings or parents had orthodontic treatment? ☐ YES ☐ NO

Has the patient ever had injuries to mouth, teeth or chin? ☐ YES ☐ NO

Does the patient like their smile? ☐ YES ☐ NO

Has the patient been informed of any missing or extra permanent teeth? ☐ YES ☐ NO

Please check if the patient has/had any of the following conditions:

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

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.

ParentSignature:_____ _____ 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

ParentSignature:_____ Date:_____