Nichols Orthodontics, Inc.

orthodontics for children & adults

Laura Nichols, DDS, MS

PATIENT INFORMATION

LAST NAME	FIRST NAME	NICKNAME	SEX ☐MALE ☐ FEMALE
MAILING ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	SOC. SEC. #	EMAIL ADDRESS	
☐ SINGLE ☐ SEPARATED ☐ MARRIED ☐ DIVORCED	HOME NUMBER	CELL NUMBER	BUSINESS NUMBER
GENERAL DENTIST	DATE OF LAST DENTAL VISIT	EMPLOYED BY/OCCUPATION	
RELATED PATIENTS THAT ARE OR HAVE BEEN IN OUR CARE	WHOM MAY WE THANK FOR RECOMMENDING US?		

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

☐ PATIENT RESPONSIBLE

FIRST & LAST NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY/OCCUPATION		
MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE
WORK/CELL PHONE	DATE OF BIRTH	SOC. SEC #	EMAIL ADDRESS	

DENTAL INSURANCE INFORMATION

DO YOU HAVE ORTHODONTIC BENEFITS? ☐ YES ☐ NO

PRIMARY INSURED'S FIRST & LAST NAME	DATE OF BIRTH	INSURANCE COMPANY NAME		
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE	PHONE
GROUP NAME	GROUP #	ID #/SOC. SEC #		

2nd INSURED'S FIRST & LAST NAME	DATE OF BIRTH	INSURANCE COMPANY NAME		
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE	PHONE
GROUP NAME	GROUP #	ID #/SOC. SEC #		

EMERGENCY CONTACT INFORMATION

CONTACT PERSON IN CASE OF EMERGENCY:_____

PHONE #:_____WORK #:_____RELATIONSHIP:_____

I consent to the dental practice using my cell phone number to (chose one or both) ☐ 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:_____ PHONE:_____

Are you currently experiencing any health problems? ☐ YES ☐ NO 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 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:

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

Are there any other conditions or problems that we should know about?

_____

_____

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 there is a history of:

☐ Clenching ☐ Muscular soreness around head and neck ☐ Jaw Joint Soreness

☐ Grinding Teeth ☐ Headache ☐ Jaw Joint Popping/Clicking ☐ Ringing in the Ear ☐ 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 needed 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:_____