Nichols Orthodontics, Inc.

orthodontics for children & adults

Laura Nichols, DDS, MS

PATIENT INFORMATION

LAST NAME	FIRST NAME	NICKNAME	SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

SCHOOL	GRADE	GENERAL DENTIST	DATE OF LAST DENTAL VISIT	CELL PHONE

WHOM MAY WE THANK FOR RECOMMENDING US?	RELATED PATIENTS THAT ARE OR HAVE BEEN IN OUR CARE

PARENT INFORMATION

SAME ADDRESS AS PATIENT ☐ YES ☐ NO EMAIL ADDRESS:_____

PARENT FIRST & LAST NAME	DATE OF BIRTH	CELL PHONE

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

PARENT INFORMATION

SAME ADDRESS AS PATIENT ☐ YES ☐ NO EMAIL ADDRESS:_____

PARENT FIRST & LAST NAME	DATE OF BIRTH	CELL PHONE

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

IF PARENTS ARE DIVORCED WHO IS THE CUSTODIAL PARENT? ☐ N/A	MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT? ☐ N/A

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

FIRST & LAST NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY/OCCUPATION

MAILING ADDRESS	CITY	STATE	ZIP	PHONE

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 #

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:_____

Is the patient currently experiencing any health problems? ☐ YES ☐ NO 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:

☐ Heart Murmur	☐ Hepatitis	☐ Emotional Disorder	☐ Heart Surgery	☐ Diabetes	☐ Fainting
☐ Rheumatic Fever	☐ Kidney Disease	☐ HIV Positive	☐Endocrine Disorder	☐ Liver Disease	☐ Allergy to Latex
☐ Cancer	☐ Tuberculosis	☐ Bone Disorder	☐ Growth Disorder	☐ Blood Disease	
☐ Asthma	☐ Mouth Breathing	☐ Developmental Disorder	☐ Epilepsy	☐ Allergies	

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

_____

_____

INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Is the patient adopted? ☐ YES ☐ NO

Height of patient: _____ Do you feel growth is completed? ☐ YES ☐ NO

Father's height: _____ Mother's height: _____

Has your son or daughter reached puberty? ☐ YES ☐ NO

Girls: Started menstruation? ☐ YES ☐ NO AGE: _____

Boys: Voice Changed? ☐ YES ☐ NO AGE: _____

DENTAL HISTORY

Does (did) your son or daughter have a finger sucking habit? ☐ YES ☐ NO

Is there any unfinished dental care? ☐ 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

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

Does the patient like his or her 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 Ears ☐ 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.

Parent Signature:_____ Date:_____