Members American Association of Orthodontists

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ORTHODONTIC SPECIALISTS

Welcome

NAHAS AND DONAHUE ORTHODONTICS

CHILDREN AND ADOLESCENTS

PATIENT INFORMATION - Please Print (Confidential)

Date _____

_____ _____ _____ _____

First Middle Last Nickname

Age _____ Date of Birth ____/____/____ Gender ___M ___F Home Phone ( ) _____

Full Home Address _____

Patient's School _____ Grade _____

Person to Contact in Case of Emergency _____ Relationship_____ Phone ( )_____
(Not Living at Same Address)

Name of Family Dentist _____ Date of Last Dental Check-up_____

Who can we thank for referring patient to our office? _____

Musical Instruments/Hobbies/Sports_____

Has patient had any Previous Orthodontic Treatment or Orthodontic Consultations? ❑ Yes ❑ No

If so, when and where? _____

What are your main concerns about the patients teeth? _____

FAMILY INFORMATION

Father's Name _____ Full Address_____

Father's Employer_____Occupation_____H Phone ( ) _____W Phone ( ) _____

Cell Phone ( ) _____Social Security Number_____

Mother's Name _____Full Address_____

Mother's Employer_____Occupation_____H Phone ( ) _____W Phone ( ) _____

Cell Phone ( ) _____Social Security Number_____

Have any of your family members been previously treated at our offices? ❑ Yes ❑ No Names_____

Patient Medical History

Physician _____ Phone ( ) _____ Date of Last Exam_____

	YES	NO
1. Is patient under medical treatment now?	❑	❑
2. Has patient ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain: _____		
3. Is patient taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) is patient taking? _____		
4. Has patient ever taken Phen-Fen/Redux?	❑	❑
5. Does patient use tobacco?	❑	❑
6. Does patient use controlled substances?	❑	❑
7. Is patient wearing contact lenses?	❑	❑

8. Does patient have or have they had any of the following?

	YES	NO
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Rheumatic Fever	❑	❑
Swollen Ankles	❑	❑
Fainting/Seizures	❑	❑
Asthma	❑	❑
Low Blood Pressure	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑
Aids or HIV Infections	❑	❑
Thyroid Problem	❑	❑
Bleeding Disorders	❑	❑
Nervous Disorders	❑	❑
Heart Disease	❑	❑
Cardiac Pacemaker	❑	❑
Heart Murmur	❑	❑
Angina	❑	❑
Frequently Tired	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Arthritis	❑	❑
Joint Replacement or Implant	❑	❑
Hepatitis/Jaundice	❑	❑
Sexually Transmitted Disease	❑	❑
Stomach Troubles/Ulcers	❑	❑
Autoimmune Disease	❑	❑
Artificial Prosthesis	❑	❑
Chest Pains	❑	❑
Easily Irritated	❑	❑
Stroke	❑	❑
Hay Fever/Allergies	❑	❑
Tuberculosis	❑	❑
Radiation Therapy	❑	❑
Glaucoma	❑	❑
Recent Weight Loss	❑	❑
Liver Disease	❑	❑
Heart Trouble	❑	❑
Respiratory Problems	❑	❑
Mitral Valve Problem	❑	❑

Other Medical Problems:

1. _____
2. _____

9. Is patient allergic to or have had any reactions to the following?

	YES	NO
Local anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list)	❑	❑

10. Women Only

a. Is patient pregnant or thinking she may be pregnant?	❑	❑
b. Is patient taking oral contraceptives?	❑	❑

Patient Dental History

DOES THE PATIENT REQUIRE ANTIBIOTICS FOR DENTAL TREATMENT? ❑ YES ❑ NO

	YES	NO
1. Do patients gum bleed while brushing or flossing?	❑	❑
2. Are teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Does patient feel pain in any teeth?	❑	❑
5. Has patient any sores or lumps in or near mouth?	❑	❑
6. Has patient had any head, neck or jaw injuries?	❑	❑
7. Has patient ever experienced any of the following problems in his/her jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑
8. Does patient have frequent headaches?	❑	❑
9. Does patient clench or grind teeth?	❑	❑
10. Does patient bit lips or cheeks frequently?	❑	❑
11. Has patient ever had difficult extractions?	❑	❑
12. Has patient ever had prolong bleeding?	❑	❑
13. Has patient ever had any orthodontic treatment?	❑	❑
14. Has patient ever received oral hygiene instructions regarding care of teeth/gums?	❑	❑
15. Does patient like their smile?	❑	❑

16. What is your chief orthodontic (dental) concern(s)?

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to patient's health. I authorize Nahas & Donahue Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Nahas & Donahue Orthodontics any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of the patient.

X_____

Signature of Parent or Guardian Relationship to Patient Date

Doctors Comments_____

_____

_____

_____ Signature_____ Date_____