Members American Association of Orthodontists

GEORGE H. NAHAS, D.D.S.
THOMAS J. DONAHUE, D.M.D.
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_____