

Nellie Gail Orthodontics

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New Patient Information (Adult)

Today's Date: _____ Patient's Name _____

Male Female Age _____ Date of Birth _____

Address _____ Home Phone _____

_____ Mobile Phone _____

Referred By: _____ Family Dentist _____

Place of Employment _____ Business Phone _____

Spouse's Name _____ Home Phone _____

Address _____ City _____ Zip _____

Place of Employment _____ Business Phone _____

Please provide the following information if you would like our office to check with your insurance carrier for orthodontic benefits:

Name of Insured _____ Date of Birth _____ SSN _____

Name of Insured _____ Date of Birth _____ SSN _____

Primary Ins. Co. _____ Group # or Plan Name _____

Secondary Ins. Co. _____ Group # or Plan Name _____

Instructions: Please answer all questions as completely and accurately as possible; your confidentiality will be respected.

What are your primary concerns that brought you to our office? _____

Please check any of the following that are concerns regarding your teeth and jaws:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> crowding | <input type="checkbox"/> overbite | <input type="checkbox"/> buckteeth |
| <input type="checkbox"/> receded jaw | <input type="checkbox"/> prominent jaw | <input type="checkbox"/> gummy smile |
| <input type="checkbox"/> spaces | <input type="checkbox"/> gum disease or recession | <input type="checkbox"/> missing teeth |

(continued) Please check any of the following that are concerns regarding your teeth and jaws:

- | | | |
|---|--|--|
| <input type="checkbox"/> jaw dysfunction | <input type="checkbox"/> clicking jaw joint | <input type="checkbox"/> mouth too small |
| <input type="checkbox"/> irregularly shaped teeth | <input type="checkbox"/> protrusion of teeth | <input type="checkbox"/> ringing/stiffness of ears |
| <input type="checkbox"/> headaches/facial pain | <input type="checkbox"/> neck pain | <input type="checkbox"/> jaw pain |
| <input type="checkbox"/> irregular facial proportions | <input type="checkbox"/> other _____ | |

Do any blood relatives have similar problems? Father Mother brother sister other _____

The following are also of interest to the orthodontist: Please check yes or no. Do you

- | YES | NO | | YES | NO | |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | snore when sleeping | <input type="checkbox"/> | <input type="checkbox"/> | breathe primarily through the mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | have frequent colds | <input type="checkbox"/> | <input type="checkbox"/> | have frequent sore throat or tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> | have difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | have difficulty chewing |
| <input type="checkbox"/> | <input type="checkbox"/> | have pain in the jaw joint | <input type="checkbox"/> | <input type="checkbox"/> | have clicking in the jaw joint |
| <input type="checkbox"/> | <input type="checkbox"/> | have speech problems | <input type="checkbox"/> | <input type="checkbox"/> | smoke |
| <input type="checkbox"/> | <input type="checkbox"/> | suck finger or thumb (ever? Y/N) | <input type="checkbox"/> | <input type="checkbox"/> | bite or suck on lip |
| <input type="checkbox"/> | <input type="checkbox"/> | If previously, age ceased _____ | <input type="checkbox"/> | <input type="checkbox"/> | grind teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | tongue thrust | <input type="checkbox"/> | <input type="checkbox"/> | other habits _____ |

Dental History:

- How often do you see the dentist? once a year twice a year or more only if urgent never
- When was your last dental checkup or cleaning? _____ Next scheduled? _____
- Has your dentist recommended any restorative work (e.g. replacement of fillings, crowns, veneers, bridges, implants, etc.)? yes no If yes, what has been recommended? _____

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- Your interest in orthodontic treatment:
 want treat if necessary unwilling, but agrees no thanks
 - Orthodontic consultation prompted by: patient dentist spouse parent _____
 - Have you ever had previous orthodontic consultation or treatment? yes no
 - Have you ever had any unusual dental experiences? yes no If yes, please explain _____
-
-

MEDICAL HISTORY

Present Health: Good Fair Poor

Have you ever had any of the following conditions? Please check yes or no for each

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	heart disease
<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	bone disorders
<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	endocrine problems	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	female problems	<input type="checkbox"/>	<input type="checkbox"/>	hearing disorder
<input type="checkbox"/>	<input type="checkbox"/>	kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV+	<input type="checkbox"/>	<input type="checkbox"/>	AIDS
<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	trauma to head

Medications: Medications that you currently take. Please check yes or no for each

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	bone density drugs (e.g. Fosamax, Boniva)	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	heart pills	<input type="checkbox"/>	<input type="checkbox"/>	Vitamins
<input type="checkbox"/>	<input type="checkbox"/>	pain pills (Codeine, Demerol, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	birth control pills
<input type="checkbox"/>	<input type="checkbox"/>	Diet Pills (diuretics, Phen-Fen, Redux, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Insulin
<input type="checkbox"/>	<input type="checkbox"/>	sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	muscle relaxants
<input type="checkbox"/>	<input type="checkbox"/>	other _____			

Have you been on any medications in the past six months that you are not currently taking? Yes No. **If yes, please circle the YES boxes above for any medications that you are not currently taking but have taken within the past six months.**

Allergies: Please check yes or no for each. You have an allergic response to

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	latex	<input type="checkbox"/>	<input type="checkbox"/>	pain pills
<input type="checkbox"/>	<input type="checkbox"/>	metals _____	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics _____
<input type="checkbox"/>	<input type="checkbox"/>	dairy products/wheat/cereals	<input type="checkbox"/>	<input type="checkbox"/>	dyes in food
<input type="checkbox"/>	<input type="checkbox"/>	other _____			

Are there any other medical, dental, or surgical problems not covered above or any conditions an orthodontist, oral surgeon, or physician should know about? yes no If yes, please explain _____

Patient's signature _____ Date _____

Doctor's Notes:
