NANCE ORTHODONTICS

Patient Insurance Information and Medical History

Confidential Patient Information

Patient's First Name:_____ Patient's Last Name:_____

Street Address:_____ City:_____

State:_____ Zip code: _____ Home Phone:_____

Mobile Phone:_____ Birth Month:_____ Birth Day:_____ Birth Year:_____

Confidential Responsible Party Information

First Name:_____ Last Name:_____

Relationship to Patient:_____

Street Address:_____ City:_____

State:_____ Zip code:_____ Home Phone:_____

Mobile Phone:_____ Birth Month:_____ Birth Day:_____ Birth Year:_____

Email:_____ Employer:_____

Occupation:_____ No. Years Employed:_____

Spouse/Partner First Name:_____ Spouse/Partner Last Name:_____

Spouse/Partner Phone:_____

How did you hear about our practice:_____

_____

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Emergency Information

Name of nearest relative not living with you?_____

Street Address:_____ City:_____

State:_____ Zip code: _____ Home Phone:_____

Mobile Phone:_____ Relationship:_____

Insurance Information

Policy Holder's Name:_____ Birthdate:_____

Social Security #:_____ Insurance Company:_____

Group Number:_____ ID Number:_____

Insurance Company Address:_____

Insurance Company Phone:_____

Policy Holder's Employer_____

Do you have dual coverage? ☐ Yes ☐ No If yes, complete below.

Policy Holder's Name:_____ Birthdate:_____

Social Security #:_____ Insurance Company:_____

Group Number:_____ ID Number:_____

Insurance Company Address:_____

Insurance Company Phone:_____

Policy Holder's Employer_____

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Medical History

General Dentist:_____ Last Cleaning:_____

Is patient in good health? ☐ Yes ☐ No

Does patient have any history of major illness? ☐ Yes ☐ No

Please list any past/current major illness:_____

Check any of the following for which the patient has been treated

AIDS & HIV	☐	Anemia	☐	Prolonged Bleeding	☐
Diabetes	☐	Epilepsy	☐	Fainting or Dizziness	☐
Pneumonia	☐	Asthma	☐	Nervous Disorders	☐
Heart Trouble	☐	Kidney Involvement	☐	Hepatitis	☐
Rheumatic Fever	☐	Tuberculosis	☐	Endocrine Problems	☐
Bone Disorders	☐				

Does patient have tendency to colds? ☐ Sore throats? ☐ Ear infections? ☐

Patient's tonsils and adenoids have been removed ☐ What age?_____

List any drugs or medications now being taken. Give reasons. _____

_____

Has the patient reached puberty? Girls - Has she started menstruation? ☐ Yes ☐ No

Boys - Has his voice changed? ☐ Yes ☐ No

Height:_____ Weight:_____

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Special Needs or Behavioral Considerations

Does the patient have any special needs, behavior considerations, disabilities, or medical conditions that our orthodontist and clinical team should be aware of?

☐ No

☐ Yes - Please explain below:

Examples may include physical disabilities, sensory sensitivities, developmental delays, autism spectrum disorder, anxiety, hearing or vision impairments, learning differences, or other medical or behavioral considerations.

Details: _____

_____

_____

_____

Is there anything specific we can do to help make the patient's visit more comfortable?

_____

_____

_____

Parent/Guardian Signature:_____

Date:_____

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Dental History

Have there been any injuries to the face, mouth, or teeth?		Yes ☐	No ☐
Has the patient ever sucked their thumb or fingers?		Yes ☐	No ☐
Does the patient have any speech impediments?		Yes ☐	No ☐
Is the patient a mouth breather?	While awake?	Yes ☐	No ☐
	While asleep?	Yes ☐	No ☐
Have you been informed of any missing or extra permanent teeth?		Yes ☐	No ☐
Has an orthodontist been consulted previously?		Yes ☐	No ☐
Has either parent had orthodontc treatment?		Yes ☐	No ☐

List any musical instruments played:_____

Reason for consultation:_____