

Patient Biographical Information

Patient's Last name: _____ First name: _____ Middle Initial: _____

Nickname: _____

Birth Date: ____/____/____ Age: ____ Sex: ☐ Male ☐ Female ☐ Other
MM DD YYYY

Home address: _____
City state Zip

Cell phone: (____) ____ - ____ Work phone: (____) ____ - ____

Home Phone: (____) ____ - ____ Email: _____

School Name: _____ Grade: _____

Preferred Appointment Confirmation Method: ☐ Text ☐ Phone Call ☐ Email _____

Have any other family members been treated in this office? Please name them: _____

Have you had any previous orthodontic treatment or consultation? _____

Whom may we thank for referring you to our practice?

- | | | |
|---|--|---------------------------------------|
| ☐ Google | ☐ Social Media (IG, FB, Tiktok) | ☐ Other: _____ |
| ☐ Website(NexusOrthodontics.com) | ☐ Existing Patient | |
| ☐ Website(Dental Insurance) | ☐ General Dentist | |

PARENT/GUARDIAN

Patient lives with (check all that apply)

☐ mother ☐ father ☐ step-parent(s) ☐ grandparents(s) ☐ Other _____

Father's full name _____ Cell phone (____) ____ - ____

Email address _____

Mother's full name _____ Cell phone (____) ____ - ____

Email address _____

Custodial parent(s) name _____

DENTIST

Patient's dentist: _____ Office Phone: (____) ____ - ____

Address/City/State/ _____

Last seen _____ Reason _____

Other dentists/dental specialists now being seen: Name _____

Office Phone (____) ____ - ____ Reason _____

Financial Party Information

☐ Check if the patient is also the person who will be financially responsible for treatment.

First Name: _____ Middle Initial _____ Last name: _____

Birthdate: _____ Relationship to patient: _____

Address (if different than page 1) _____ City, State, Zip _____

Cell phone _____ Home phone _____

E-mail address(es) _____ Social Security# _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____

Next appointment: _____ Most recent physical exam: _____

Other physician/ health care providers being seen now:

Name: _____ City, State _____

Reason: _____

Is the patient now under the care of a physician (other than routine)? If so what is being treated?

☐ Yes ☐ No

DENTAL INSURANCE

Primary policy holder's full name: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____ Relationship to patient: _____

Insurance company: _____ Employer: _____

ID#: _____ Group#: _____

Address _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name: _____ Date of Birth: _____

Social Security#: _____ - _____ - _____ Relationship to patient: _____

Insurance company: _____ Employer: _____

ID#: _____ Group#: _____

Address: _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Your answers are confidential and for office records only. A thorough medial history is essential to a complete orthodontic evaluation. For following questions mark yes, no or don't know/understand (dk/u)

MEDICAL HISTORY

- | | |
|--|---|
| ☐ Yes ☐ no ☐ dk/u Birth defects or hereditary problems? | ☐ Yes ☐ no ☐ dk/u Treated for Emotional Problems |
| ☐ Yes ☐ no ☐ dk/u Bone fractures, or major Injuries? | ☐ Yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia) |
| ☐ Yes ☐ no ☐ dk/u Arthritis or joint problems? | ☐ Yes ☐ no ☐ dk/u Asthma, sinus problems, Hayfever |
| ☐ Yes ☐ no ☐ dk/u Endocrine or thyroid problems/ | ☐ Yes ☐ no ☐ dk/u Heart defects, heart murmur, rheumatic heart disease |
| ☐ Yes ☐ no ☐ dk/u Kidney problems? | ☐ Yes ☐ no ☐ dk/u Angina, arteriosclerosis, stroke or heart attack. |
| ☐ Yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy | ☐ Yes ☐ no ☐ dk/u Do you eat a well-balanced Diet? |
| ☐ Yes ☐ no ☐ dk/u Stomach ulcer, hyperacidity, acid reflux | ☐ Yes ☐ no ☐ dk/u Take Bisphosphonates |
| ☐ Yes ☐ no ☐ dk/u Immune system problems? | ☐ Yes ☐ no ☐ dk/u Tonsil or adenoid condition |
| ☐ Yes ☐ no ☐ dk/u History of osteoporosis | ☐ Yes ☐ no ☐ dk/u Do you frequently breathe through your mouth |
| ☐ Yes ☐ no ☐ dk/u Gonorrhea, syphilis, sexually transmitted diseases? | ☐ Yes ☐ no ☐ dk/u Hormone Therapy? |
| ☐ Yes ☐ no ☐ dk/u AIDS or HIV positive? | ☐ Yes ☐ no ☐ dk/u High or low blood pressure? |
| ☐ Yes ☐ no ☐ dk/u Hepatitis, jaundice or other liver problems? | ☐ Yes ☐ no ☐ dk/u Speech Problems/Therapy? |
| ☐ Yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia? | ☐ Yes ☐ no ☐ dk/u Frequent headaches? |
| ☐ Yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem? | |
| ☐ Yes ☐ no ☐ dk/u Diabetes or low sugar | |
| ☐ Yes ☐ no ☐ dk/u Mental health disturbance or Depression? | |

ALLERGIES

Have you had allergies or reaction to any of the following?

- ☐ Yes ☐ no ☐ dk/u Local anesthetics (Novocain, lidocaine, xylocaine)
- ☐ Yes ☐ no ☐ dk/u Aspirin, Ibuprofen, Tylenol
- ☐ Yes ☐ no ☐ dk/u Penicillin or other antibiotics
- ☐ Yes ☐ no ☐ dk/u Latex (gloves, balloons)
- ☐ Yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
- ☐ Foods:
- ☐ Other:

Please select **YES** or **NO** if the patient has had any of the conditions
listed below either now or in the past.

- ☐ Yes ☐ No ☐ dk/u Lip Sucking/Biting
- ☐ Yes ☐ No ☐ dk/u Thumb/Finger Sucking
- ☐ Yes ☐ No ☐ dk/u Clenching/Grinding Teeth
- ☐ Yes ☐ No ☐ dk/u Frequent/canker sores or cold sores?
- ☐ Yes ☐ No ☐ dk/u Have you noticed any changes in your face or jaws

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication_____Taken for_____

Medication_____Taken for_____

Have you ever taken any medications to strengthen your bones? Please describe.

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Do you or have you ever had a substance abuse problem? ☐ Yes ☐ No

Do you chew or smoke tobacco? ☐ Yes ☐ No

Women: Are you pregnant ☐ Yes ☐ No

Women: Are you trying to become pregnant? ☐ Yes ☐ No

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

And I authorize the release of my dental records and related information to other dental or medical offices as necessary for my care and treatment

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completions of this form. I will notify my orthodontist of any changes in my medical or dental health.

Patient's name: _____ Patient's signature _____

Guardian's name _____ Guardian's signature _____

Date _____