NASH ORTHODONTICS
Enhancing Smiles. Enriching Lives.

Welcome to Nash Orthodontics

Medical and Dental History Form

Member American Association of Orthodontists®

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

SSN: _____ - _____ - _____ Sex: Male / Female Birth Date: _____ /_____ /_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Email Address: _____ @ _____

School/Occupation: _____ Grade: _____ Sports/Hobbies: _____

Who can we thank for referring us? _____

Marital Status: Single Married Widowed Separated Divorced

If divorced, who is the custodial parent? _____

May patient information be released to the non-custodial parent? Yes No

Who is the responsible party? Father Mother Other: _____

Parent Information | Please complete if patient is a minor.

Father's Name: _____ SSN: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ /_____ /_____ Email Address: _____ @ _____

Occupation: _____ Day Phone: _____

Mother's Name: _____ SSN: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ /_____ /_____ Email Address: _____ @ _____

Occupation: _____ Day Phone: _____

Dental Insurance

Does your insurance have orthodontic coverage? Yes No Name of Insurance Company: _____

Policy Holder: _____ Birth Date: _____ /_____ /_____

SSN: _____ - _____ - _____ Policy Number: _____

Employer: _____ Group Number: _____

Provider's Phone Number: _____

Dentist Information

Name of Dentist: _____ Phone Number: _____

Date of Last Visit: _____ /_____ /_____

Orthodontic Concerns:

What would you like treatment to accomplish? _____

_____

Medical History:

Physician: _____ Phone Number: _____ Last Seen: _____ /_____ /_____

For the following questions, please circle YES or NO. The answers are for our office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation and diagnosis.

Do you have now or have had in the past:

Birth defects or hereditary problems?	Yes	No	Excessive bleeding or bruising tendency, anemia or bleeding disorder?	Yes	No
Bone fractures, any major accidents?	Yes	No	High or low blood pressure?	Yes	No
Rheumatoid or arthritic conditions?	Yes	No	Tire Easily?	Yes	No
Endocrine or thyroid problems?	Yes	No	Chest pain, shortness of breath or swelling ankles?	Yes	No
Kidney Problems?	Yes	No	Diabetes? Type I Type II	Yes	No
Hepatitis, jaundice or liver problem?	Yes	No	Skin disorder?	Yes	No
Cancer, tumor, radiation treatment or chemotherapy?	Yes	No	Frequent headaches, colds or sore throats?	Yes	No
Stomach ulcer or hyperactivity?	Yes	No	Eye, ear, nose or throat condition?	Yes	No
Polio, mononucleosis, tuberculosis or pneumonia?	Yes	No	Fainting spells, seizures, epilepsy or neurological problem?	Yes	No
Problems or the immune system?	Yes	No	Mental health disturbance or depression?	Yes	No
AIDS or HIV positive?	Yes	No	Vision, hearing, tasting or speech difficulties?	Yes	No
Loss of weight recently, poor appetite?	Yes	No	Cardiovascular problem?	Yes	No
Easting Disorder (anorexia, bulimia)?	Yes	No	Hay fever, asthma, sinus trouble or hives?	Yes	No
Osteoporosis?	Yes	No	Tonsil or adenoid conditions?	Yes	No
Other conditions?				Yes	No
Operations:				Yes	No
Hospitalized?				Yes	No
Current medications, supplements, herbal medications or non-prescription medicine?				Yes	No
Are there any other medical conditions that we should be aware of?				Yes	No

Allergies or Reactions:

Metals (Jewelry/Nickel)	Yes	No
Latex	Yes	No
Penicillin or other antibiotics	Yes	No
Other:	Yes	No

Dental History:

Permanent or "Extra" (Supernumerary) teeth removed?	Yes	No	Any pain in jaw or ringing in the ears?	Yes	No
Supernumerary (extra) or congenitally missing teeth?	Yes	No	Pain or soreness in muscles of the face or around ears, TMJ/TMD?	Yes	No
Chipped of otherwise injured primary or perm. teeth?	Yes	No	Difficulty in chewing or jaw opening?	Yes	No
Teeth sensitive to hot or cold; teeth throb or ache?	Yes	No	Aware of loose, broken or missing restorations (fillings)?	Yes	No
Jaw fractures, cysts or mouth infections?	Yes	No	Any teeth irritating cheek, lip, tongue or palate?	Yes	No
"Dead Teeth" or root canals treated?	Yes	No	Concerned about spaced crooked or protruding teeth?	Yes	No
Bleeding gums, bad taste or mouth odor?	Yes	No	Aware or concerned about under or over developed jaw?	Yes	No
Periodontal "gum problems"?	Yes	No	"Gum boils," frequent canker sores or cold sores?	Yes	No
Food impaction between teeth?	Yes	No	Taking any form of fluoride?	Yes	No
Thumb, finger or sucking habit? Unit what age?	Yes	No	Any relative with similar tooth or jaw relationship?	Yes	No
Abnormal swallowing habit (tongue thrust)?	Yes	No	Had periodontal (gum) treatment?	Yes	No
History of speech problems?	Yes	No	Any serious trouble associated with any previous dental treatment?	Yes	No
Mouth breathing habit, snoring or difficulty in breathing?	Yes	No	Any prior orthodontic examination or treatment?	Yes	No
Tooth grinding or jaw clenching?	Yes	No	Orthodontist Name:	Date:	

By signing I am acknowledging that I am the legal guardian and that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform and necessary dental serviced that the patient my need during diagnosis and treatment with my informed consent.

Signature : _____ Date: _____ /_____ /_____

Printed Name: _____ Relationship to Patient: _____

Reviewed by Dr. Nash: _____