For office use only:

**PT #**

## *PATIENT HISTORY FORM*

DATE ____________________

Name ____________________________________________________ Social Security # ________________________

Birth date ________________ Age ________ Phone/Cell _________________ Email___________________I____________________

Address __________________________________________________ City ____________________State _____ Zip ________

Siblings / children in treatment here ______________________________________________________________________________

Who can we thank for referring you to our office? ____________________________________________________________________

Dentist _________________________________ Phone __________________ Address __________________________________

Physician:_______________________________ Phone __________________ Address __________________________________

For Children:

Parents / Legal Guardian Name ________________________________________ Phone # __________________________

________________________________________ Phone # __________________________

For Adult Patients:
Spouse's Name ________________________________________ Phone ____________________

Person Financially Responsible _______________________________________ Relationship _______________________

Social Security # __________________________________ Phone __________________________

Address _____________________________________________ City/State__________________________ Zip_________________

**MEDICAL HISTORY.** (Circle yes or no and fill in blanks where required)

1. Are you/patient in good health? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No
2. Date of last dental exam __________________ Is work completed? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No
3. Is Patient Adopted? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No
4. Have tonsils and/or adenoids been removed? At what age? _________ . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No
5. Are height and weight normal for age? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No
6. Frequent colds, sore throat, or ear infections? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No
7. Any allergies, latex allergies, metal allergies or drug sensitivity? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No

   If yes, list ______________________________________________________________________________________
8. Taking medication now? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No

   If yes, list ______________________________________________________________________________________
9. Under medical care now? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes No

   If yes, reason ____________________________________________________________________________________
10. Circle any of the following for which you have been treated:

| Diabetes | Asthma | Prolonged bleeding | Tonsillitis | Osteoporosis | ADHD |
|---|---|---|---|---|---|
| Arthritis | Epilepsy | Nervous disorders | Brain injury | HIV | Autism |
| Heart trouble | Rheumatic fever | Endocrine problems | Tuberculosis | Cancer | Anxiety |

**Any other medical conditions not listed above?** _____________________________________________________________

______________________________________________________________________________________________________

**** PLEASE COMPLETE OTHER SIDE ****

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## *PATIENT HISTORY FORM*

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**DENTAL HISTORY**: (circle answer)

1. Have there been any injuries to the face, mouth, or teeth? . . . . . . . . . . No Yes
2. Have you ever sucked your thumb or fingers? Until what age? __________ . . . . . . . . No Yes
3. Have you ever had habits, such as lip biting or tongue thrusting or fingernail biting? . . . . . . No Yes
4. Do you have any speech problems?. . . . . . . . . . No Yes
5. Have you ever had any speech therapy? . . . . . . . . . . No Yes
6. Are you a mouth breather while asleep or awake? . . . . . . . . . . No Yes
7. Are you aware of any missing or extra permanent teeth? . . . . . . . . . . No Yes
8. Any previous orthodontic treatment? . . . . . . . . . . No Yes

   if so, Name of orthodontist ____________________________________________
9. What are you or your dentist most concerned about? ____________________________________________

____________________________________________

______________________________________________ ______________________________

(Signature) Parent/Legal Guardian if minor Date

______________________________

Relationship if Minor

AUTHORIZATIONS

I authorize Nordstrom Orthodontics LLC to submit to my insurance and authorize payment of orthodontic benefits otherwise payable to me, directly to Nordstrom Orthodontics LLC

BENEFITS OF ORTHODONTICS

AESTHETICS, HEALTH AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and understand the above paragraph. I also understand that my diagnostic records may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in the above medical or dental history.

______________________________________________ ______________________________________________

Patient (Parent Legal Guardian if minor) Date

CREDIT REFERENCES MAY BE CHECKED ______________________________________________