NIA JONES ORTHODONTICS

Patient _____
Last First M.I.
Nickname _____ Birth date ___ /___/___ Age_____ Male___ Female___
Address_____
Street City Zip Code

Adult Patient Information ONLY:
Phone: Home_____ ____ Cell_____ Work_____
E-mail_____ Married_____ Divorced_____ Single_____
Employer_____ Length of employment_____

Child's Responsible Party Information
Mother___ Step Mother___ Guardian_____
Last First M.I.
Address (if different than patient's) _____
Street City Zip Code
Phone: Home_____ Cell_____ Work_____
E-mail_____ Married_____ Divorced_____ Single_____
Employer_____ _____ _____ Length of employment_____
Father__ Step Father___ Guardian_____
Last First M.I.
Address (if different than patient's) _____
Street City Zip Code
Phone: Home_____ Cell_____ Work_____
E-mail_____ Married_____ Divorced_____ Single_____
Employer_____ Length of employment_____

Sibling Info: Name _____Birth date ___ /___/___ Male___ Female__
Name _____Birth date ___ /___/___ Male___ Female___
Name _____Birth date ___ /___/___ Male___ Female___

Dental Insurance Information
Orthodontic Coverage Yes_____ No_____
Primary Insured's Name
_____
Last First Middle Initial
Birth date ___ /___/___Age____ Relationship to Patient _____
Employer_____ Insurance Co. _____ Address _____
Subscriber/Member ID NO._____ Group No._____

Secondary Insured's Name
_____
Last First Middle Initial
Birth date ___ /___/___Age____ Relationship to Patient _____
Employer_____ Insurance Co. _____ Address _____
Subscriber/Member ID NO._____ Group No._____

Signature_____ Date_____

Medical History

Physician_____ Date of last visit_____
Address_____ Phone_____
Please circle Yes or No (If yes, please fill in details)

Yes No Are you taking any medications? _____
Yes No Are you allergic to any medication?_____
Yes No Are you allergic to any materials (metal, latex, etc.)? _____
Yes No Have you had any major operations or been involved in a serious accident?_____
Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Snoring
Anemia	Heart murmur	Herpes	Sleep Apnea
Arthritis	Epilepsy	High Blood Pressure	Asthma
Hay fever	Gastrointestinal Disorders	HIV/AIDS	Bed Wetting
Heart Problems	Kidney Problems	Tuberculosis	Dizziness
Congenital Heart Defect	Tumor or Cancer	Nervous Disorders	Headaches
Pneumonia	Radiation/Chemotherapy	Rheumatic Fever	Speech Issues

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

Height of patient_____ If patient is under 18 years old, height of parents: Mom _____ Dad _____

Female Patients only:

Yes No Has menstruation started? At what age? _____
Yes No Are you pregnant? _____

Dental History

Dentist _____ Date of last visit _____
What concerns you most about your teeth _____

Yes No Have you ever seen an orthodontist? If yes, who and when?_____
Yes No Has anyone in your family received orthodontic treatment? _____
Yes No Family history of an under bite?_____
Yes No Family history of jaw surgery? _____
Yes No Do you have anxiety with dental visits?_____
Yes No Are you presently in any dental pain? _____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure?_____
Yes No Do your gums bleed when you brush?_____
Yes No Do you have any thumb, finger or tongue habits? _____
Yes No Are you a mouth breather? _____
Yes No Are you aware of your jaw popping or clicking? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____
Yes No Are you aware of clenching? Have you been told that you grind your teeth?_____

Other

Yes No Are you aware that some appointments will be during school/work hours?

Please list any hobbies or interests: _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Nia Jones Orthodontics, P.C. to perform a complete orthodontic evaluation including diagnostic records of photos, X-rays, and a digital scan.

Signature: _____ **Date:** _____