NALIN | ORTHODONTICS

ANDREW M. NALIN, DDS, PS
PRACTICE LIMITED TO ORTHODONTICS

BOX # _____
WL _____
A / S / O _____

Tell Us About You:

Date: _____/_____/_____ Time: _____

Name: _____ ___M ___F
Last First

Birthdate: _____/_____/_____ Age: _____ SS# _____

Dentist: _____ Referred by: _____

Home # (_____) _____ Cell # (_____) _____

Address: _____

Employer: _____Wk # (_____) _____

Spouse/Partner Information:

His/Her Name: _____

Employer: _____

Hm # (_____) _____ Cell # (_____) _____

Wk # (_____) _____ SS# _____

Birthdate: _____/_____/_____

E-mail: _____

Orthodontic Insurance

Primary Coverage: ___Yes ___No

Insurance Co. Name: _____

Insurance Co. Phone: (_____) _____ Group # _____

Policy Owner Name: _____ Birthdate: _____

Relation to Patient: _____ ID# _____

Employer: _____ SS# _____

Secondary Coverage: ___Yes ___No

Insurance Co. Name: _____

Insurance Co. Phone: (_____) _____ Group # _____

Policy Owner Name: _____ Birthdate: _____

Relation to Patient: _____ ID# _____

Employer: _____ SS# _____

Medical History

What are the main concerns that you would like orthodontics to address?

Have you been evaluated or had orthodontic treatment before?

Have there been any injuries to the face, mouth, teeth or chin?

Do you require antibiotics before dental treatment?

Have your adenoids or tonsils been removed?

Do you have missing or extra permanent teeth?

Have you ever had any pain/tenderness in your jaw joint?

Do you clench or grind your teeth?

Are you currently under the care of a physician?

Do you smoke or use tobacco in any other form?

Have you experienced any of the following medical problems?

- ___ Abnormal Bleeding/Anemia
- ___ AIDS/HIV+
- ___ Osteoporosis
- ___ High or low blood pressure
- ___ Artificial Bones/Joints/Valves
- ___ Asthma
- ___ Cancer
- ___ Cardiovascular Problems
- ___ Convulsions
- ___ Diabetes
- ___ Epilepsy/Fainting/Seizures
- ___ Vision or Speech Difficulties
- ___ Birth defects/hereditary prob
- ___ Endocrine/Thyroid problems
- ___ Recent weight loss
- ___ Tire Easily
- ___ Shortness of breath
- ___ Frequent headaches
- ___ Rheumatoid/arthritic conditions
- ___ Hearing Impairment
- ___ Hemophilia
- ___ Heart Murmur
- ___ Hepatitis
- ___ Kidney Problems
- ___ Liver Problems
- ___ Mitral Valve Prolapse
- ___ Prosthetics
- ___ Rheumatic Fever
- ___ Mononucleosis
- ___ Depression
- ___ Polio
- ___ Bone fractures
- ___ Stomach ulcer/hyperacidity
- ___ History of eating disorder
- ___ Chest pain
- ___ Skin Disorder
- ___ Frequent colds/sore throats

(Please continue on reverse side)

Name: _____ Age: _____ Sex: _____

Have you had any metal rods, pins or implants?

Have you ever taken bisphosphonates?
(i.e. Fosamax, Boniva, etc.)

Indicate your current physical health: ___GOOD___FAIR___POOR

Women: Are you pregnant?

Please list all medications that you are currently taking & for what:

_____

_____

Please list any other serious medical problems that you have had:

_____

_____

Do you have allergies to any of the following?

Family members in practice: _____

___Latex ___Nickel/Metals___Acrylic___Aspirin___Codeine___Ibuprofen ___Penicillin/other antibiotics (list): _____

List any other drug/material allergies: _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ADA. I understand that the information I have given is correct to the best of my knowledge and will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I authorize the dental staff to perform the necessary dental/orthodontic services that I may need.

_____

Patient Signature Date

(office use only)

1. Angle Classification:

	RIGHT SIDE		LEFT SIDE	
	MOLAR	CANINE	MOLAR	CANINE
CLASS I				
CLASS II				
DIV II				
CLASS III				

2. Dentition Notes:

3. Arch Length: Maxillary _____ mm Crowded Spaced
Mandibular _____ mm Crowded Spaced

4. Crossbites:

5. Overjet: _____ mm Normal ☐ Edge/Edge ☐ Crossbite ☐
6. Overbite: _____ mm Normal ☐ Open Bite ☐ Impingement ☐
7. Midlines: Maxillary _____ mm Left/Right Mandibular _____ mm Left/Right
8: Recession:
9. Abnormal Frenum: Maxillary Mandibular
10. TMJ Hx:
11. Habits:
12. Oral Hygiene: Good ☐ Fair ☐ Poor ☐

TX Type: Full Ltd:
Est Months: 6 12 13-17 18-24 25+
Records: $

Pano: Yes ☐ No ☐ Comments:

DATE	OPERATION PERFORMED	NEXT APPOINTMENT	MONTHS