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

BOX # _____
WL _____
A / S / O _____

Tell Us About Your Child:

Date: _____/_____/_____ Nickname: _____

Child's Name: _____
LAST FIRST MI

Birthdate: _____/_____/_____ Age: _____ ___ M ___ F

Dentist: _____ Referred by: _____

Confirm Appointments at this # (_____) _____

Child's Address: _____

_____

Person(s) Responsible for Account:

Name: _____ Relation: _____

Billing Address: _____

_____

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

Employer: _____

Work # (_____) _____ SS# _____

Birthdate: _____ E-Mail: _____

Parental Information

___ Mother ___Stepmother ___ Guardian Custody?___Y ___ N

Name: _____ Birthdate: _____

Wk # (____) _____ Hm # (____) _____

Employer: _____ SS# _____

___ Father ___ Stepfather ___ Guardian Custody? ___Y___ N

Name: _____ Birthdate: _____

Wk # (____) _____ Hm # (____) _____

Employer: _____ SS# _____

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?

_____

Has your child been evaluated or had orthodontic treatment before?

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

Does the child require antibiotics before dental treatment?

Have adenoids or tonsils been removed?

Does your child have missing or extra permanent teeth?

Has the child ever had any pain/tenderness in his/her jaw joint?

Has the child experienced any of the following medical problems?

- ____ Abnormal Bleeding
- ____ AIDS/HIV+
- ____ ADD/ADHD
- ____ Hospital Stays/Operations
- ____ Artificial Bones/Joints/Valves
- ____ Asthma
- ____ Cancer
- ____ Congenital Heart Defect
- ____ Convulsions
- ____ Diabetes
- ____ Epilepsy
- ____ Handicaps/Disabilities
- ____ Hearing Impairment
- ____ Hemophilia
- ____ Heart Murmur
- ____ Hepatitis
- ____ Kidney Problems
- ____ Liver Problems
- ____ Mitral Valve Prolapse
- ____ Prosthetics
- ____ Rheumatic Fever
- ____ Scarlet Fever
- ____ Sickle Cell Disease
- ____ Tuberculosis (TB)

(Please continue on reverse side)

Name: _____ Age: _____ Sex: _____

Does the child brush teeth daily? ____Y ____N Floss daily? ____Y ____N

Is the child currently under the care of a physician? ____ Y____ N

Has puberty begun? ___Y ___N GIRLS: Has menstruation begun? ___Y ___N

Does/did the child have any of the following habits?

____ Speech Problems	____ Lip Sucking/Biting
____ Mouth Breather	____ Thumb/Finger Sucking
____ Tongue Thrust	____ Nail Biting
____ Pacifier Usage	____ Nursing/Bottle Habits
	____ Clenching/Grinding Teeth

Indicate the child's current physical health: ___GOOD ___FAIR ___POOR

Is the child allergic to any medications? _____

Please list all medications that the child is currently taking:

_____

Please list any other serious medical problems the child has had:

_____

Does your child have allergies to any of the following?
___ Latex ___ Nickel/Metals ___ Plastic ___ Anything else? _____

List any musical instruments played: _____

Other family members in practice? _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and 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 child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services that my child may need.

_____
Signature of Parent or Guardian 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: PHI Full Ltd:
Est Months: 6-9 10-12 13-17 18-24 25+
Records: $

Pano: Yes ☐ No ☐ Comments:

DATE	OPERATION PERFORMED	NEXT APPOINTMENT	MONTHS