NELSON
Pediatric Dentistry & Orthodontics

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Preferred Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient Employer (if applicable) _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ May We Text You? ☐ Yes ☐ No

Employer _____ Work Phone _____ SS#/SIN _____

Is this person accompanying the patient in our office today? ☐ Yes ☐ No (If No, who is?) _____

Relationship to Patient _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company Phone _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company Phone _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are your immunizations up to date?	☐	☐
2. Are you under medical treatment now?	☐	☐
3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Do you have or have you had any of the following?		

	Yes	No
9. Are you wearing contact lenses?	☐	☐
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women Only:	☐	☐
a) Has menstruation started?	☐	☐
b) Are you pregnant or think you may be pregnant?	☐	☐
c) Are you nursing?	☐	☐
d) Are you taking oral contraceptives?	☐	☐

	Yes	No
Genetic Syndrome	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
ADHD	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Chicken Pox, Mumps, Measles	☐	☐

	Yes	No
Eating Disorders	☐	☐
Heart Disease	☐	☐
Autism	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Heart Surgery	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Stomach Troubles / Ulcers	☐	☐
Please elaborate if necessary: _____		

	Yes	No
Acid Reflux/Chronic Vomiting	☐	☐
Cleft Palate	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Ear Infections/Tubes	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Other _____	☐	☐

Patient Dental History

Name of Dentist _____ Date of Last Exam _____

	Yes	No
1. Have you ever had any trauma to the mouth?	☐	☐
2. Do you feel pain to any of your teeth?	☐	☐
3. Have you had any head, neck or jaw injuries?	☐	☐
4. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
5. Do you have frequent headaches?	☐	☐
6. Do you clench or grind your teeth?	☐	☐
7. Do you bite your lips or cheeks frequently?	☐	☐
8. Have you ever had any prolonged bleeding following extractions?	☐	☐
9. Have you ever seen an orthodontist?	☐	☐
10. Do you like your smile?	☐	☐
11. Have you ever had a thumb or finger sucking habit?	☐	☐

Authorization and Release

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I request and authorize that Nelson Pediatric Dentistry & Orthodontics to provide necessary dental care for this child/patient. I authorize the use of diagnostic aids, medications, patient photos and procedures that are necessary in the professional judgement of Nelson Pediatric Dentistry & Orthodontics. I have read, understood, and agree to the terms outlined in the financial and treatment policy. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Finance charges may be incurred on past due balance.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____ Signature _____ Date _____