NORDBERG ORTHODONTICS

Welcome to our office and thank you for coming!

PATIENT

Last Name		First Name	
Birth Date		Gender	
School		Interests/Hobbies	

PRIMARY RESPONSIBLE PARTY

☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Other _____

Last Name		First Name		Nickname	
Birth Date				Gender	
E-mail				Social Security #	
Mailing Address				Home Phone #	
Years at this address?		Own or Rent?		Cell Phone #	
Employer				Work Phone #	
Occupation				# Years Employed	
Marital Status	☐ Single ☐Married ☐Divorced ☐Separated ☐Widowed				
Dental Insurance Company				Ins. Phone #	
Insurance Address				Group/ID #	

SECONDARY RESPONSIBLE PARTY

☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Other _____

Last Name		First Name		Nickname	
Birth Date				Gender	
E-mail				Social Security #	
Mailing Address				Home Phone #	
Years at this address?		Own or Rent?		Cell Phone #	
Employer				Work Phone #	
Occupation				# Years Employed	
Marital Status	☐ Single ☐Married ☐Divorced ☐Separated ☐Widowed				
Dental Insurance Company				Ins. Phone #	
Insurance Address				Group/ID #	
How did you hear about us	Dentist Hygienist Acquaintance Family Other_____				
Whom may we thank you for referring you to us					
Please describe the primary orthodontic concern for you child					

DENTAL & MEDICAL HISTORY

Dentist's Name:		Phone #	
Frequency of dental checks: ☐Twice a year ☐Once a year ☐Only if problems exists ☐Never Date of last visit: _____			
Does your child have any unfinished dental care?	☐Yes - Please explain		
Is your child nervous about dental treatment?	☐Yes - Please explain		
Is there any history of face or dental injuries?	☐Yes - Please explain		
Is there any history of thumb or finger sucking?	☐Yes Stopped?	☐No When?	
Have you consulted an orthodontist previously for you child?	☐Yes If yes, with Whom?		
Has your child had any previous orthodontic treatment?	☐Yes If yes, with Whom?		

Please check if you child now has (or has had in the past) any of the following:

- ☐ Adenoidectomy
- ☐ Autoimmune Disorder
- ☐ ADD/ADHD
- ☐ Aids
- ☐ Allergy: Metal
- ☐ Allergy: Penicillin
- ☐ Allergy: Other _____
- ☐ Allergy: Seasonal
- ☐ Anemia / Bleeding
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chest Pains
- ☐ Cold Sores/Herpes
- ☐ Developmental Disorder
- ☐ Diabetes
- ☐ Downs Syndrome
- ☐ Emotional Disorder
- ☐ Endocrine Problems
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Growth Disorder
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Organ Transplant
- ☐ Rheumatic Fever
- ☐ Tonsillectomy
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Osteoporosis

Is your child still growing in height ☐ Yes ☐ No
Does your child smoke? ☐ Yes ☐ No How Much? _____
Females: Currently Pregnant? ☐ Yes ☐ No
Any disease, health problems, or allergies not mentioned above? _____
Current medications? _____

Signature: _____ Relationship to Patient: _____ Date: _____