Celebrate Your Smile!
Noorda ORTHODONTICS

1701 N. Green Valley Parkway
Henderson, NV 89074

Patient Form - Orthodontics

Patient Information

Patient #:_____ Appt:___ / __ / __ Age:___ School: _____ Grade:_____

Patient Name:_____
Last First Middle

Address:_____
Street City State Zip Code

Birthdate:_____M/F Social Security #:____-____-_____Home Phone:_____Cell Phone:_____

Email Address:_____If patient is a minor, parent's or guardian's name:_____

Other family members treated here Y/N If yes, names:_____

Whom may we thank for referring you to our office?_____

Responsible Party/Legal Guardian Information

Name:_____Marital Status:_____
Last First Middle

Residence:_____
Street City State Zip Code

Mailing Address:_____
Street City State Zip Code

How long at this address?_____Home Phone:_____Cell Phone:_____Work Phone:_____

Previous Address (if less than 3 years):_____

Social Security #:____-____-_____Birthdate:_____Relationship to patient:_____

Employer:_____Occupation:_____# of years:_____

Spouses Name:_____Relationship to patient:_____

Social Security #:____-____-_____Birthdate:_____Work Phone:_____Cell Phone:_____

Employer:_____Occupation:_____# of years:_____

Insurance Information

Insured's Name:_____Relationship:_____

Birth date:_____SS#SID _____

Employer:_____

Occupation:_____ Date of Emp.:_____

Ins. Company:_____Group:_____Emp.:_____

Ins. Company Address:_____

Deductible:_____Amount already Used:_____Max Benefit: ___

Orthodontic Coverage: Yes____No____ Effective Date:_____

Emergency Information

Relative or Friend not living with you:_____

Address:_____

Phone:_____

Dentist Information

Dentist's Name:_____

Date of last cleaning:_____

Dentist's Main Concern:_____

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models and photographs to make a thorough diagnosis of the patients orthodontic needs. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor):_____Date:_____

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Health History

Physician's Name:_____Phone #:_____

Are you currently under a physician's care? Reason:_____

Are you taking any medications?_____

Are you aware of being allergic to or have you ever reacted adversely to any medication?_____

Has an orthodontist been consulted previously? Y___N___ If so, who?_____

Have you had orthodontics in the past?_____

Please check box if you now have or have had:

- ☐ Aids
- ☐ Allergies/Sinus trouble
- ☐ Anemia
- ☐ Asthma
- ☐ Bone disorders
- ☐ Blood disease
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Epilepsy
- ☐ Faintness/Dizziness
- ☐ Fever blisters
- ☐ Headaches (frequent)
- ☐ Heart murmur
- ☐ Hemophiliac
- ☐ Hepatitis
- ☐ HIV positive
- ☐ TMJ problems

- ☐ Any injuries to face, mouth, teeth? (circle)
- ☐ Thumb, finger, lip sucking? (circle)
- ☐ Mouth-breathing when awake, asleep? (circle)
- ☐ Any missing/extra permanent teeth?
- ☐ Is there a tongue thirst problem?
- ☐ Any teeth removed by extraction?
- ☐ Any speech problems?
- ☐ Any pain or clicking on opening mouth?
- ☐ Are you aware of an uncomfortable or bad bite?
- ☐ Any jaw symptoms or headaches upon waking each morning?
- ☐ Have you been treated for jaw or muscle, or joint disorder?
- ☐ Do you smoke?
- ☐ Latex Allergy?
- ☐ Cheek, tongue, or lip chewing?
- ☐ Clenching teeth?
- ☐ Fingernail biting?
- ☐ Other oral health:_____

Are you aware of any other disease, condition or problem not listed above that we should know about?_____

In your own words, describe your orthodontic problem and what you would like orthodontic treatment to accomplish:___