Celebrate Your Smile!

Noorda ORTHODONTICS

1701 N. Green Valley Parkway
Henderson, NV 89074

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Patient ID#:_____ Today's Date:_____

Your Child

Name: _____
Nickname: _____
Birth date: _____
Sex: _____
Age: _____
SS#SIN: _____
School: _____
Grade: _____
Home Address: _____
_____
City: _____
State:_____ Zip:_____
Phone: _____

Mom/Step Mom/Guardian

Name: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
SS#SIN: _____
Employer: _____
Occupation: _____
DL#: _____

Dad/Step Dad/Guardian

Name: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
SS#SIN: _____
Employer: _____
Occupation: _____
DL#: _____

Parent's Marital Status

Single____ Divorced____ Married____ Widowed____ Separated____

Responsible Party

Name: _____
Relationship: _____
Address: _____
_____
SS#SID: _____
DL#: _____
Email: _____

Primary Dental Insurance

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:_____

Who will be making appointments?

Name: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Best time to call: _____
Best day to call: _____

Additional Insurance

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:_____

Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives.
Please answer each of the following questions completely.

History

Has your child had difficulty with previous visits? Y___N___

Does your child have a persistent cough or throat-clearing not associated with a known illness (for more then 3 weeks)? Y__N__

Has your child ever had any of the following:

Asthma	Y___N___	Rheumatic Fever	Y___N___
Cancer	Y___N___	Congenial Heart Defect	Y___N___
HIV/AIDS	Y___N___	Handicaps/Disabilities	Y___N___
Hemophilia	Y___N___	Convulsions/Epilepsy	Y___N___
Diabetes	Y___N___	Tuberculosis	Y___N___
Allergies	Y___N___	Abnormal Bleeding	Y___N___
		Heart Murmur	Y___N___

Please explain any medical problems that your child has:_____

_____

_____

_____

Habits

How often does your child brush?_____

How often does your child floss?_____

Date of last dental visit?_____

Previous Dentist _____

Child's Physician _____

Phone Number _____

Child's birth date _____

Is your child's water fluoridated? Y___N___

Does your child take fluoride supplements Y___N___

Does your child:

Suck thumb/finger Y___N___

Suck/Bite lips Y___N___

Bite/Chew nails Y___N___

Bite/Chew (Pencils, etc.) Y___N___

Grind teeth Y___N___

Clench jaws Y___N___

Authorization and release

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of 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 services that my child may need.

Signature of Parent or guardian:_____ Date:_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian:_____ Date:_____

Dentist's Review

_____

_____

_____

_____

_____

_____

_____

Signed Dr._____Date_____

Health History Update

Date_____Comments_____

_____

_____

Signature_____

Date_____Comments_____

_____

_____

Signature_____