nadeau
ORTHODONTICS
spectacular smiles & confident tomorrows

Welcome to our practice! All of us at Nadeau Orthodontics, P.A. thank you for choosing us for your orthodontic needs. We pride ourselves in ensuring our patient's and their families receive both outstanding orthodontic treatment and exemplary customer service. In order for us to fulfill our promise please take a few minutes to complete our patient registration form, medical health history form, and dental health history form.

Thank you!

# PATIENT REGISTRATION

Today's Date: _____
Patient's Last Name: _____ First: _____ Middle: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone number to confirm appointments: _____ SS Number: _____
Birth Date: _____ Age: _____ Sex: ____ Marital Status: _____

Whom should we thank for referring you to our office? _____
Have any of your friends or other family members been treated in our office?_____

**Patient Information**

Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email address: _____
Employer: _____
Employer Address: _____

**Spouse Information**

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Employer: _____
Employer Address: _____

Person responsible for the account: _____
Person to contact in case we cannot reach you: _____ Phone: _____

## ORTHODONTIC INSURANCE

**Primary Coverage**

Insurance Co: _____
Phone: _____
Group Number: _____
Subscriber Name: _____
Subscriber SS #: _____
Date of Birth: _____

**Secondary Coverage**

Insurance Co: _____
Phone: _____
Group Number: _____
Subscriber Name: _____
Subscriber SS#: _____
Date of Birth: _____

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# ADULT MEDICAL HEALTH HISTORY

***Your responses to the following questions are for our office records only and will be considered confidential.***

Describe your overall health: Excellent Good Fair Poor

Yes / No Have you ever been hospitalized? If yes, please explain:_____

Yes / No Are you *allergic* to any drug or other substance? If yes, please list:_____

Yes / No Are you *allergic* to latex?

Yes / No Are you currently taking any drugs or medication? If yes, please list:_____

Yes / No Has a health care provider ever informed you that you require pre-medication before dental treatment?

Yes / No Have you ever experienced bleeding that was hard to stop?

Yes / No Have you ever used a tobacco containing product? If yes, please explain:_____

**PLEASE CIRCLE ALL CONDITIONS THAT APPLY TO YOU.**

| | | |
|---|---|---|
| Heart murmur | Endocrine or thyroid problems | Immune system disorders |
| Heart surgery | Kidney problems | AIDS or HIV positive |
| Rheumatic/ Scarlet Fever | Diabetes | Cancer |
| Heart pacemaker | Hepatitis, jaundice, liver disorders | Epilepsy, seizures, or fainting spells |
| Artificial heart valve | Tumor treatment | Neurological problems |
| Chest pain or shortness of breath | Polio, Mono, Tuberculosis | Mental health problems |
| Tires easily | Pneumonia | Emotional or behavioral problems |
| Artificial joints | Vision, hearing, or speaking problems | Sinus problems |
| High or Low blood pressure | Eye, ear, nose, or throat condition | Frequent headaches |
| Bleeding disorder or anemia | Asthma | TMJ problems |
| Birth defects or hereditary problem | Hay fever | Tactile defensive |
| Past operations | Past or present substance abuse problems | |

**PLEASE INITIAL HERE IF NONE OF THE ABOVE CONDITIONS APPLY TO YOU.** _____

*Females:* Are you pregnant? Yes / No

# ADULT DENTAL HEALTH HISTORY

Name of your dentist: _____ Last visit: _____

How often do you brush you teeth? _____ Floss? _____

What is your primary concern? Why are you here? _____

Who first noticed a need for orthodontic treatment? _____

What is your main concern regarding your orthodontic tx? QUALITY DISCOMFORT COST APPEARANCE TIME

**PLEASE CHECK THE LINE IF THE CONDITION(S) APPLIES TO YOU.**

| | |
|---|---|
| ___ Started teething very early or late? | ___ Limited jaw opening? |
| ___ Missing teeth? | ___ Pain in the jaw or muscles of the face? |
| ___ Extra (supernumerary) teeth? | ___ Teeth grinding? |
| ___ Chipped or otherwise injured teeth? | ___ Thumb or finger sucking habit? Until what age? _____ |
| ___ Jaw fractures, cysts, or infections? | ___ Abnormal swallowing habit? |
| ___ Extracted teeth? | ___ Speech problems? |
| ___ Teeth sensitive to hot or cold? | ___ Mouth breathing habit? |
| ___ Loose or broken fillings? | ___ Snoring? |
| ___ Food impaction between teeth? | ___ Under or over developed jaw? |
| ___ Teeth irritating the cheek or gums? | ___ Relatives with similar teeth or jaw relationships? |
| ___ Wisdom teeth problems? | ___ Previous orthodontic treatment? |
| ___ Sore or bleeding gums? | ___ Previous orthodontic evaluation? How long ago? _____ |

**I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I WILL NOT HOLD DR. NADEAU OR ANY MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM. IF THERE ARE ANY CHANGES LATER TO THIS HISTORY RECORD OR MEDICAL / DENTAL STATUS I WILL INFORM THIS PRACTICE.**

_____ _____

Signature of patient Date