

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: _____ Email Address: _____
 Birth Date: _____ Age: _____ Sex: _____ School: _____

Whom should we thank for referring you to our office? _____
 Have any of your friends or other family members been treated in our office? _____
 Favorite sports, Hobbies & Avocations: _____
 Musical instrument played: _____

Father

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

Mother

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

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

ORTHODONTIC INSURANCE

Primary Coverage

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

Secondary Coverage

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



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CHILD MEDICAL HEALTH HISTORY

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

Describe your child's overall health: Excellent Good Fair Poor

Yes / No Has your child ever been hospitalized? If yes, please explain: _____

Yes / No Is your child *allergic* to any drug or other substance? If yes, please list: _____

Yes / No Is your child *allergic* to latex?

Yes / No Is your child currently taking any drugs or medication? If yes, please list: _____

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

Yes / No Has your child's tonsils and/or adenoids been removed?

PLEASE CIRCLE ALL CONDITIONS THAT APPLY TO YOUR CHILD.

- | | | |
|-------------------------------------|---------------------------------------|--|
| 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 | Smoking or other tobacco use |

PLEASE INITIAL HERE IF NONE OF THE ABOVE CONDITIONS APPLY TO YOUR CHILD. _____

Males: Has your child's voice changed? Yes / No If yes, when? _____

Females: Has your child started menstruating? Yes / No If yes, when? _____

CHILD DENTAL HEALTH HISTORY

Name of your child's dentist: _____ Last visit: _____

How often does your child brush their 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 child's orthodontic tx? QUALITY DISCOMFORT COST APPEARANCE TIME

PLEASE CHECK THE LINE IF THE CONDITION(S) APPLIES TO YOUR CHILD.

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

Date