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 patients 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, medical health history, 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: ____

Parent/Guardian

Name: ______________________________
Address: ___________________________
Home Phone: ________________________
Work Phone: ________________________
Cell Phone: _________________________
Email address: ______________________
Employer: __________________________
Employer Address: ___________________
Position: ___________________________

Parent/Guardian

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.

___ 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 parent or guardian Date