nordberg orthodontics
ON CANYON ROAD

Welcome to our office and thank you for coming!

Please complete all information.

PATIENT

Last Name		First Name		Nickname	
Birth Date				Gender	
E-mail				Social Security #	
Mailing Address				Home Phone #	
Years at this address?		Own or Rent?		Carrier and Cell Phone #	
Employer				Work Phone #	
Occupation				# Years Employed	
Marital Status	☐ Single ☐Married ☐Divorced ☐Separated ☐Widowed				
Dental Insurance Company				Ins. Phone #	
Insurance Address				Group/ID #	

SPOUSE

Last Name		First Name		Nickname	
Birth Date				Gender	
E-mail				Social Security #	
Mailing Address				Home Phone #	
Years at this address?		Own or Rent?		Carrier and Cell Phone #	
Employer				Work Phone #	
Occupation				# Years Employed	
Marital Status	☐ Single ☐Married ☐Divorced ☐Separated ☐Widowed				
Dental Insurance Company				Ins. Phone #	
Insurance Address				Group/ID #	
How did you hear about us	Dentist Hygienist Acquaintance Family Other_____				
Whom may we thank you for referring you to us					
Please describe your orthodontic concerns in your own words					

DENTAL & MEDICAL HISTORY

Dentist's Name:		Phone #	
Frequency of dental checks: ☐Twice a year ☐Once a year ☐Only if problems exists ☐Never Date of last visit: _____			
Is there any unfinished care to be completed with you dentist?	☐Yes - Please explain		
Are you nervous about dental treatment?	☐Yes - Please explain		
Have you had any face or dental injuries?	☐Yes - Please explain		
Is there any history of thumb or finger sucking?	☐Yes Stopped?	☐Yes ☐No When?	
Have you consulted an orthodontist previously?	☐Yes Whom?		
Has you had any previous orthodontic treatment?	☐Yes With Whom?		

Please check if you now have (or has had in the past) any of the following:

Jaw Joints/Head & Neck Muscles

- ☐ Head/Neck Muscle Soreness
- ☐ Jaw Joint Popping or Clicking
- ☐ Difficult/Painful Chewing
- ☐ Mouth Breathing
- ☐ Clenching Teeth
- ☐ Frequent Headaches
- ☐ Grinding Teeth
- ☐ Speech Problems
- ☐ Jaw Joint Soreness
- ☐ Ringing in the Ears
- ☐ Chronic Neck Pain

Medical History:

- ☐ Adenoidectomy
- ☐ Autoimmune Disorder
- ☐ ADD/ADHD
- ☐ Aids
- ☐ Allergy: Metal
- ☐ Allergy: Penicillin
- ☐ Allergy: Other _____
- ☐ Allergy: Seasonal
- ☐ Anemia / Bleeding
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chest Pains
- ☐ Cold Sores/Herpes
- ☐ Developmental Disorder
- ☐ Diabetes
- ☐ Downs Syndrome
- ☐ Emotional Disorder
- ☐ Endocrine Problems
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Growth Disorder
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Organ Transplant
- ☐ Rheumatic Fever
- ☐ Tonsillectomy
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Osteoporosis

Do you smoke? ☐ Yes ☐ No How Much? _____

Females: Are you currently pregnant? ☐ Yes ☐ No

Any disease, health problems, or allergies not mentioned above? _____

Current medications? _____

Have you received any of the following IV bisphosphonate medications (usually for cancer treatment): Aredia, Zometa, Bonefos ☐ Yes ☐ No

Signature: _____ Relationship to Patient: _____ Date: _____