NATHAN DAVIS
orthodontics

Patient Overview

mesa/gilbert (480) 969 8500 *chandler* (480) 897 8588

Patient Information

Name _____
First M/I Last Nickname

Age _____ Birth Date _____ Sex _____ E-mail _____

Address _____ Phone _____
City Zip Code

Emergency Contact Name _____ Relationship to Patient _____

Emergency Contact Address _____ Phone _____

Responsible Party Information

Father/Guardian Or Self Info (If Adult)

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Physical Address _____

Previous Address _____

How long have you lived at current address? _____

How long have you lived at previous address? _____

Home Ph. _____ Work Ph. _____ Mobile Ph. _____

E-mail _____

Age _____ Birthday _____ Relationship to Patient _____

Driver's License# _____ S.S.# _____

Marital Status: ◯ *Single* ◯ *Married* ◯ *Separated* ◯ *Divorced* ◯ *Widowed*

Mother Info

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Physical Address _____

Previous Address _____

How long have you lived at current address? _____

How long have you lived at previous address? _____

Home Ph. _____ Work Ph. _____ Mobile Ph. _____

E-mail _____

Age _____ Birthday _____ Relationship to Patient _____

Driver's License# _____ S.S.# _____

Marital Status: ◯ *Single* ◯ *Married* ◯ *Separated* ◯ *Divorced* ◯ *Widowed*

Employer Information

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Occupation _____ No. of Years Employed _____

Orthodontic Coverage? ◯ Yes ◯ No

Insurance Company Name _____

Insurance Address _____

Insurance Phone _____

Group No. _____

Plan No. _____

Insurance I.D. _____

Secondary/Dual Insurance? ◯ Yes ◯ No

Employer Information

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Occupation _____ No. of Years Employed _____

Orthodontic Coverage? ◯ Yes ◯ No

Insurance Company Name _____

Insurance Address _____

Insurance Phone _____

Group No. _____

Plan No. _____

Insurance I.D. _____

Secondary/Dual Insurance? ◯ Yes ◯ No

Other Information

Person Responsible for Account _____

Other Children/Siblings _____ Age _____

_____ Age _____

_____ Age _____

School Name _____

Instruments Played? _____

Sports Played? _____

Other Hobbies? _____

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Patient Information

Name _____
First M/I Last

Dentist Name _____ Phone _____

Approximate Date of Last Visit _____

Physician Name _____ Phone _____

Approximate Date of Last Visit _____

Who May We Thank for Referring You to Our Office? _____

For Office Use	A B C

Medical Information (check all that apply)

- ◯ AIDS/HIV Positive
- ◯ Anemia
- ◯ Anxiety
- ◯ Arthritis
- ◯ Artificial heart valves/joints
- ◯ Asthma
- ◯ Back/Neck Problems
- ◯ Bleeding or Bruising Problems
- ◯ Blood Disease
- ◯ Blood Pressure High/Low
- ◯ Bone Disease
- ◯ Cancer or Tumors
- ◯ Chemical Dependence
- ◯ Diabetes
- ◯ Endocrine Disease
- ◯ Epilepsy
- ◯ Fainting or Dizziness
- ◯ Heart Disease
- ◯ Heart Murmur
- ◯ Hepatitis
- ◯ Kidney Problems
- ◯ Liver Disease
- ◯ Migraines
- ◯ Nervous/Emotional Problems
- ◯ Psychological/Psychiatric Care
- ◯ Respiratory Disease
- ◯ Rheumatic Fever
- ◯ Skin Problems/Rashes
- ◯ Stroke
- ◯ Tobacco Use (current or past)
- ◯ Tonsils or Adenoids removed
- ◯ Thyroid Disease
- ◯ Tuberculosis
- ◯ Venereal Disease
- ◯ Vision/Hearing Deficiency

Allergy/Sensitivity

- ◯ Local Anesthetics (Lidocaine)
- ◯ Advil/Ibuprofen
- ◯ Hay Fever
- ◯ Pollen/Seasonal Allergies
- ◯ Latex Allergy
- ◯ Nickel Allergy
- ◯ Food Allergies

_____

- ◯ Allergies to Medication

_____

Women Only

Are you pregnant or could you be pregnant? ◯ Yes ◯ No

Are you anticipating becoming pregnant? ◯ Yes ◯ No

Please List All Medications

Medication Taken For?

_____

_____

_____

Nutrient Supplements, Herbal Medication or Nonprescription Medicine

_____

_____

_____

Please list any problems not mentioned that we should know about:

_____

Dental History (check all that apply)

- ◯ Has the patient seen a General Dentist in the last year
- ◯ Is there any current dental work needed
- ◯ Has the mouth, face or teeth been injured by fall or accident
- ◯ Mouth breathing habit, snoring or difficulty in breathing
- ◯ Frequent canker sores or cold sores
- ◯ Abnormal swallowing habit
- ◯ Tongue thrust
- ◯ Thumb or finger sucking
- ◯ Speech problems or speech therapy
- ◯ Are you missing any teeth or have extra permanent teeth
- ◯ Clenching or grinding teeth
- ◯ Headaches or earaches
- ◯ Any pain, clicking or locking in jaw or ringing in ears
- ◯ Difficulty in chewing or jaw opening
- ◯ Have you ever been treated for "TMD" or "TMJ"
- ◯ Periodontal problems (gums)
- ◯ Has the patient ever been examined by an orthodontist before? If yes, when and by whom? _____
- ◯ Have other family members had orthodontic treatment? _____

Areas Of Concern (Select All That Apply)

◯ Crowding ◯ Protrusion ◯ Cross-bite ◯ Missing Teeth ◯ Speech Problems
◯ Jaw Soreness ◯ Uneven Bite (Bite-Off) ◯ Slow Eruption of Adult Teeth
Other _____

Do you have any other concerns you would like us to know about your teeth or smile? _____

What would you like to improve about your teeth or smile? _____

How do you feel about wearing braces? _____

Any questions for our staff? _____

I understand that the information I have given on this form is accurate and that I am obligated to inform Dr. Davis immediately if any information changes in the future. I understand that where appropriate, credit reports ("soft inquiry") may be obtained. I hereby consent to the taking of X-rays, photographs and other necessary records.

Signature of Patient or Parent/Guardian _____ Date _____