NRHORTHODONTICS

Where beautiful smiles are made

8601 Mid Cities BLVD, North Richland Hills, TX 76182
Phone: 817-581-8881 • Fax: 817-581-4337 • www.NRHorthodontics.com

WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (Middle) Gender: _____ Marital Status: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Birthdate: _____ (Month / Day / Year) E-mail: _____ Social Security #: _____ (xxx-xx-xxxx)

Home Phone: _____ (xxx-xxx-xxxx) Cell Phone: _____ (xxx-xxx-xxxx) Work Phone: _____ (xxx-xxx-xxxx) Ext: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Whom may we thank for referring you to our office: _____

Sports and Hobbies: _____

Do you play any musical instruments? ☐ Yes ☐ No If yes, please list: _____

SPOUSE / ADDITIONAL CONTACT INFORMATION

Name: _____ (Last) _____ (First) _____ (Middle) Gender: _____ Marital Status: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Birthdate: _____ (Month / Day / Year) E-mail: _____ Relationship to Patient: _____

Home Phone: _____ (xxx-xxx-xxxx) Cell Phone: _____ (xxx-xxx-xxxx) Work Phone: _____ (xxx-xxx-xxxx) Ext: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

INSURANCE INFORMATION

Policy Owner's Name: _____ Policy Owner's Social Security #: _____ (xxx-xx-xxxx)

Policy Owner's Birthdate: _____ (Month / Day / Year) Relationship to Patient: _____

Policy Owner's Employer: _____ Employer's Address: _____

Insurance Company: _____ Group No. (plan, local, or policy): _____

Insurance Company Address: _____ Insurance Phone: _____

SECONDARY INSURANCE INFORMATION

Policy Owner's Name: _____ Policy Owner's Social Security #: _____ (xxx-xx-xxxx)

Policy Owner's Birthdate: _____ (Month / Day / Year) Relationship to Patient: _____

Policy Owner's Employer: _____ Employer's Address: _____

Insurance Company: _____ Group No. (plan, local, or policy): _____

Insurance Company Address: _____ Insurance Phone: _____

Please continue ↓

MEDICAL HISTORY

Are you under the care of a physician? ☐ Yes ☐ No If Yes, explain: _____

Physician: _____ Phone: _____ Last Visit: _____

Address: _____

If female, are you currently pregnant? ☐ Yes ☐ No If Yes, how many weeks? _____

Now or in the past, have you had…

☐ Yes	☐ No	☐ Unsure	AIDS or HIV positive?	☐ Yes	☐ No	☐ Unsure	Endocrine disorders?
☐ Yes	☐ No	☐ Unsure	Anemia?	☐ Yes	☐ No	☐ Unsure	Epilepsy?
☐ Yes	☐ No	☐ Unsure	Arthritis?	☐ Yes	☐ No	☐ Unsure	Fainting spells?
☐ Yes	☐ No	☐ Unsure	Asthma?	☐ Yes	☐ No	☐ Unsure	Headaches? Frequency_____
☐ Yes	☐ No	☐ Unsure	Birth defects/hereditary problems?	☐ Yes	☐ No	☐ Unsure	Hepatitis?
☐ Yes	☐ No	☐ Unsure	Behavioral, emotional, or learning disorder? Please Specify_____	☐ Yes	☐ No	☐ Unsure	Herpes?
				☐ Yes	☐ No	☐ Unsure	Heart trouble?
☐ Yes	☐ No	☐ Unsure	Bleeding disorders?	☐ Yes	☐ No	☐ Unsure	High blood pressure?
☐ Yes	☐ No	☐ Unsure	Bone disorders?	☐ Yes	☐ No	☐ Unsure	Immune disorders?
☐ Yes	☐ No	☐ Unsure	Bone fractures?	☐ Yes	☐ No	☐ Unsure	Muscle disorders?
☐ Yes	☐ No	☐ Unsure	Cancer or tumors?	☐ Yes	☐ No	☐ Unsure	Nervous disorders?
☐ Yes	☐ No	☐ Unsure	Diabetes?	☐ Yes	☐ No	☐ Unsure	Rheumatic Fever?
☐ Yes	☐ No	☐ Unsure	Dizziness?	☐ Yes	☐ No	☐ Unsure	Tonsil or adenoid conditions?
☐ Yes	☐ No	☐ Unsure	Eating disorders?	☐ Yes	☐ No	☐ Unsure	Tuberculosis?

Are you allergic to any of the following...

☐ Yes ☐ No ☐ Unsure Latex?

☐ Yes ☐ No ☐ Unsure Any Metal or Plastic?

List any other allergies or sensitivities: _____

Medications:

☐ Yes ☐ No ☐ Unsure Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them and what they are taken for:

_____

Are there any major illnesses or medical conditions not mentioned above that we should be aware of?

_____

_____

DENTAL HISTORY

Name of General Dentist: _____ Phone: _____ Last Visit: _____

What are the main concerns you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No When? _____

If Yes, please explain: _____

Have your tonsils or adenoids been removed? ☐ Yes ☐ No

Now or in the past, have you had…

☐ Yes	☐ No	☐ Unsure	Started teething very early or late?	☐ Yes	☐ No	☐ Unsure	Abnormal swallowing habit (tongue thrusting)?
☐ Yes	☐ No	☐ Unsure	Teeth sensitive to hot or cold?				
☐ Yes	☐ No	☐ Unsure	Chipped or injured baby or permanent teeth?	☐ Yes	☐ No	☐ Unsure	Thumb, finger or lip sucking? Until what age? _____

Please continue ⬇

DENTAL HISTORY (continued)

Now or in the past, have you had…

☐ Yes	☐ No	☐ Unsure	Jaw fractures or other trauma to the neck, head and jaw area?	☐ Yes	☐ No	☐ Unsure	Frequent canker sores?
☐ Yes	☐ No	☐ Unsure	Tooth grinding and/or jaw clenching?	☐ Yes	☐ No	☐ Unsure	Gums bleed when brushed or flossed?
☐ Yes	☐ No	☐ Unsure	Jaw popping and/or clicking?	☐ Yes	☐ No	☐ Unsure	Wisdom teeth extracted?
☐ Yes	☐ No	☐ Unsure	Pain in jaw when chewing or ringing in ears?	☐ Yes	☐ No	☐ Unsure	Extra or missing teeth from birth?
☐ Yes	☐ No	☐ Unsure	Pain or soreness in the muscles of the face or around the ears?	☐ Yes	☐ No	☐ Unsure	Periodontal "gum" problems?
☐ Yes	☐ No	☐ Unsure	Chronic neck pain?	☐ Yes	☐ No	☐ Unsure	Been under the care of a dental specialist? Specialist: _____
☐ Yes	☐ No	☐ Unsure	Difficulty encountered in chewing or jaw opening?	☐ Yes	☐ No	☐ Unsure	Taking any forms of fluoride?
☐ Yes	☐ No	☐ Unsure	History of speech problems? Under the care of a speech therapist?	☐ Yes	☐ No	☐ Unsure	Any serious trouble associated with previous dental treatment?
☐ Yes	☐ No	☐ Unsure	Mouth breathing habit?	☐ Yes	☐ No	☐ Unsure	Any relative with similar tooth or jaw relationships?
☐ Yes	☐ No	☐ Unsure	Snoring or difficulty breathing?				Sensitive or self-conscious about teeth?

Are there any dental conditions not mentioned above that we should be aware of?

_____

_____

SIGNATURE

I certify that I have read and understand the above. I will not hold NRH Orthodontics or any employee of NRH Orthodontics responsible for any problems arising out of inadequate information. I will inform NRH Orthodontics of any changes in medical status at future appointments.

I grant authority to NRH Orthodontics to perform all records, procedures, and treatments in my best interest.

I understand that, where appropriate, credit reports may be obtained.

I also understand that this initial appointment includes the oral examination and consultation with Dr. Fallah for a pre-disclosed fee. All diagnostic records are needed for a thorough diagnosis; this includes the following: written treatment plan and records. These are included in the treatment fee but billed separately to my insurance carrier if treatment is not initiated.

Signature (patient): _____ Date: _____

Signature (doctor): _____ Date: _____

I give permission to NRH Orthodontics to use ☐ my treatment photos (before/after) for patient education ☐ my photos for social media

Signature (patient): _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been informed of, have received, or have been offered a copy of this office's Notice of Privacy Practices (Health Insurance Portability & Accountability Act.)

Signature: _____ Date: _____

~ Office Use Only ~

Written acknowledgement could not be documented due to:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other, please specify: _____