NRH ORTHODONTICS

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

*We would like to **welcome** you and your child 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: M F

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

Birthdate: _____ (Month / Day / Year) School : _____ Grade: _____

Home Phone: _____ (xxx-xxx-xxxx) General Dentist: _____ Last Visited: _____

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: _____

Brothers / Sisters (include ages): _____

PARENT INFORMATION - FATHER

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

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

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

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

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

Relationship to Patient: _____

PARENT INFORMATION - MOTHER

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

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

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

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

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

Relationship to Patient: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

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

Phone: _____ (xxx-xxx-xxxx) Relationship to Patient: _____

Please continue ➔

INSURANCE INFORMATION

Policy Owner's Name: _____ Policy Owner's Social Security #: _____

Policy Owner's Birthdate: _____ 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 #: _____

Policy Owner's Birthdate: _____ Relationship to Patient: _____

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

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

Insurance Company Address: _____ Insurance Phone: _____

MEDICAL HISTORY

Is the child currently under the care of a physician? ☐ Yes ☐ No If Yes, explain: _____

Physician: _____ Phone: _____ Last Visit: _____

Address: _____

Now or in the past, has the patient 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? How frequent_____
☐ Yes	☐ No	☐ Unsure	Birth defects/hereditary problems?	☐ Yes	☐ No	☐ Unsure	Hepatitis?
☐ Yes	☐ No	☐ Unsure	Behavioral, emotional, or learning disorder? Pleas list _____	☐ 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?

Is your child allergic to any of the following...

☐ Yes ☐ No ☐ Unsure Any Metal or Plastic

☐ Yes ☐ No ☐ Unsure Latex

List any other allergies or sensitivities: _____

Medications:

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

_____

Women and Girls Only:

☐ Yes ☐ No ☐ Unsure Has the patient started her monthly periods? Approximately when? _____

☐ Yes ☐ No ☐ Unsure Is the patient pregnant?

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

_____

_____

Please continue ➔

DENTAL HISTORY

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

Has the patient ever been evaluated for orthodontic treatment? ☐ Yes ☐ No When? _____

If Yes, please explain: _____

Has the patient's tonsils or adenoids been removed? ☐ Yes ☐ No

Now or in the past, has the patient 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? _____
☐ 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	Extra or missing teeth from birth?
☐ Yes	☐ No	☐ Unsure	Pain in jaw when chewing or ringing in ears?	☐ Yes	☐ No	☐ Unsure	Periodontal "gum" problems?
☐ Yes	☐ No	☐ Unsure	Pain or soreness in the muscles of the face or around the ears?	☐ Yes	☐ No	☐ Unsure	Been under the care of a dental specialist? Specialist: _____
☐ Yes	☐ No	☐ Unsure	Chronic neck pain?	☐ Yes	☐ No	☐ Unsure	Taking any forms of fluoride?
☐ Yes	☐ No	☐ Unsure	Bed wetting	☐ Yes	☐ No	☐ Unsure	Any serious trouble associated with previous dental treatment?
☐ Yes	☐ No	☐ Unsure	History of speech problems? Under the care of a speech therapist?	☐ Yes	☐ No	☐ Unsure	Any relative with similar tooth or jaw relationships?
☐ Yes	☐ No	☐ Unsure	Mouth breathing habit?				
☐ Yes	☐ No	☐ Unsure	Snoring or difficulty breathing?	☐ Yes	☐ No	☐ Unsure	Sensitive or self-conscious about teeth?

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

_____

_____

Which best describes the patient's attitude toward orthodontic treatment: ☐ Very Motivated ☐ Will Cooperate, if needed ☐ Not Motivated

INFORMATION AND HEALTH HISTORY 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 the patient's 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 (parent, if patient is a minor): _____ Date: _____

Signature (doctor): _____ Date: _____

I give permission to NRH Orthodontics to use ☐ the patient's treatment photos (before/after) for educational purposes ☐ the Patients photo for social media

Signature (parent, if patient is a minor): _____ 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 (parent, if patient is a minor): _____ 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: _____