NDS Orthodontics
Dr. Steven W. Gajda

Today's date: _______________

Child's name: ____ Nickname: ___________________________

Date of birth: _______________ Sex: M or F Best contact phone #: ___________________________

Address:____

City:____ State: ______________ Zip: ________________

Name of school: ___________________________ Siblings (ages): ______________________________________

Whom may we thank for referring your child to our office?____

PARENT INFORMATION:

Father's name: ____ Date of birth: ____________________

Email address:____

Mobile#: _______________________________________ Mobile Carrier:_________________________________

Employer: ______________________________________ Occupation: _________________________________

Address if different from patients:____

Mother's name:____ Date of birth: ___________________

Email address:____

Mobile#: _______________________________________ Mobile Carrier:_________________________________

Employer: ______________________________________ Occupation: _________________________________

Address if different from patients:____

Send Appointment reminders to: ❑Mother by ❑Email ❑Text ❑Both / ❑Father by ❑Email ❑Text

PRIMARY INSURANCE:

Insured Person's Name: ____ Date of Birth: ________________

Employer Name: ___________________________________ Name of Insurance:________________________

SSN/ID#:_______________________ Group#________________ Insurance Phone: ____________________

Insurance Address: ____

SECONDARY INSURANCE:

Insured Person's Name: ____ Date of Birth: ________________

Employer Name: ___________________________________ Name of Insurance:________________________

SSN/ID#:_______________________ Group#________________ Insurance Phone: ____________________

Insurance Address: ____

DENTAL HISTORY:

Dentist's name: _____________________________________ Date of last cleaning? __________________

1.) Do your child's gums bleed when brushing? Yes or No

2.) Does your child suck their fingers or thumb? Yes or No If in the past, age stopped ________

3.) Does your child have any clicking, popping or pain in the jaw joint? Yes or No

4.) Does your child clench or grind their teeth? Yes or No

5.) Does your child have any problems opening or closing their mouth? Yes or No

6.) Has your child ever injured or had trauma to their teeth, face or jaw? Yes or No If yes, please explain: ___

7.) Has your child had prior orthodontic treatment in the past? Yes or No

8.) Has your child ever been advised by their physician to take an antibiotic prior to dental treatment? Yes or No If yes, please explain: ___

9.) Is there any dental work in progress or that needs to be completed? Yes or No

10.) What is your main concern about your child's teeth? ___

___

MEDICAL HISTORY:

Physician's name: ___ Date of last visit: ___

1.) Does your child have health problems, disorders or conditions that may affect orthodontic treatment? Yes or No If yes explain: ___

___

2.) Does your child have any allergies to medications? Yes or No If yes, please list:

___

3.) Allergic to LATEX? Yes or No Other Allergies? Yes or No ___

4.) Medications that they are CURRENTLY taking: ___

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CHILD'S HEALTH HISTORY:

Birth Problems………………..	Yes or No	Emotional or Behavior Problems….	Yes or No
Speech Problems……………	Yes or No	Hearing Problems………………………..	Yes or No
Tonsils/Adenoids Problems.	Yes or No	Growth Problems…………………………..	Yes or No
Attention Deficit Disorder…	Yes or No	Heart Murmur………………………………..	Yes or No
Diabetes………………………….	Yes or No	Rheumatic Fever…………………………..	Yes or No
Arthritis…………………………….	Yes or No	Anemia………………………………………….	Yes or No
Cancer…………………………….	Yes or No	Radiation Therapy………………………..	Yes or No
Sickle Cell Anemia……………	Yes or No	Cerebral Palsy……………………………..	Yes or No
Bleeding or Hemophilia………	Yes or No	Seizures………………………………………..	Yes or No
Blood Transfusions…………..	Yes or No	Asthma………………………………………….	Yes or No
Hepatitis…………………………..	Yes or No	Cleft Lip or Palate……………………….	Yes or No
AIDS or HIV+……………………	Yes or No	Eye Problems…………………………….	Yes or No
Tuberculosis……………….….	Yes or No	Liver Disease…………………………….	Yes or No
Sleep Apnea…………………….	Yes or No	Kidney Disease………………………….	Yes or No
Osteoporosis…………………….	Yes or No	Skin Problems…………………………….	Yes or No

Explain yes answers here: ___

___

___

Parent's Signature: ___ Date: ___