



The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate the better we can care for you

Welcome

To Dr. Nisco's Office

About You

Today's Date _____

E-mail Address: _____

Name: _____
Last First Mi Mr. Mrs. Ms Dr

I prefer to be called _____ Male Female

Birthdate: ___/___/___ Age: ___ SS# _____

Home Address: _____

City State Zip

Single Married Divorce Widowed Separated

Hm #: _____ Cell/Other: _____

Wk #: _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Person Responsible for Account: _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk#: _____ Ext: _____ SS#: _____

Relative or Friend not living with you.

His/her Name: _____

Wk #: _____ Hm #: _____

Orthodontic Insurance

Primary

Orthodontic Coverage? Yes No

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address _____

City State Zip

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: ___/___/___ **Insured's ID #:** _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Secondary

Orthodontic Coverage? Yes No

Dental Coverage? Yes No

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: ___/___/___ **Insured's ID #:** _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Payment is due in full at the time of treatment

Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods,pins or implants? Yes No

Are you taken any prescription/over the counter drugs?

Please list each one: _____

Have you ever taken Phen-Fen? Yes No

Also known as Redux or Pondimin.

If so when: _____

For women: Are you taken birth control pills? Yes No

Are you Pregnant? Yes No Weeks #: _____

Are you nursing? Yes No

Have you ever have any of the following diseases or medical problems:

- | | |
|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes,Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease/Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay fever | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|--------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicilin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Trtracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list any other drugs/materials that you are allergic to: _____

Dental History

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

Have you ever been evaluated for orthodontic treatment? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain discomfort in your jaw joint(TMJ/TMD)? Yes No

Your current dental health is: Yes No

Do you still have wisdom teeth? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? Yes No

Do you generally breathe through our mouth? Yes No

If yes, please circle: While awake? While asleep?

Do you have any missing or extra permanent teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature _____ Date _____

OFFICE USE ONLY

I have verbally reviewed the medical/dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments:

Our office HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Yes No

If yes, please explain: _____

_____ Patient Signature _____ Date _____

_____ Dentist Signature _____ Date _____