Novick ORTHODONTICS

Children & Adolescent New Patient Form

PATIENT INFORMATION

Name _____Date_____

Nickname_____

Birthdate_____/_____/_____Age_____ ❑ M ❑ F

Address_____

City _____State _____Zipcode _____

Cell Phone_____ Home Phone_____

Favorite Sports or Hobbies_____

School _____Grade_____

Siblings: Name _____DOB_____

Name _____DOB_____

Name _____DOB_____

Parent or Legal Guardian_____

Patients Residence: ❑ Both Parents ❑ Mother ❑ Father

Other_____

In case of Emergency Contact_____

Phone #_____Relationship_____

Dentist_____ Last visit_____

INSURANCE INFORMATION ❑ YES ❑ NO

Primary Insurance Company_____

Insured Name_____

Insured Name's Date of Birth _____/_____/_____

Contact #_____Group #_____

Subscriber #_____Employer_____

Secondary Insurance Company_____

Insured Name_____

Insured Name's Date of Birth _____/_____/_____

Contact #_____Group #_____

Subscriber #_____Employer_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

❑ Dentist_____

❑ Friend_____

❑ Internet _____

❑ Other_____

PARENT 1 INFORMATION

❑ Mom ❑ Step Mom ❑ Guardian ❑Father ❑ Step Father

Name _____ Birthdate _____/_____/_____

Address_____

City_____ State_____ Zipcode _____

Cell #_____Home #_____

Wk # _____

Employer _____Job title_____

No. of years employed: _____Marital Status ❑ S ❑ M ❑ D

SSN_____DL#_____

Email _____

PARENT 2 INFORMATION

❑ Mom ❑ Step Mom ❑ Guardian ❑Father ❑ Step Father

Name_____ Birthdate_____/_____/_____

Address_____

City_____ State_____ Zipcode_____

Cell #_____Home #_____

Wk # _____

Employer_____ Job title_____

No. of years employed: _____Marital Status ❑ S ❑ M ❑ D

SSN_____DL#_____

Email _____

RESPONSIBLE PARTY

(MAIN CONTACT PERSON REGARDING TREATMENT OR FINANCIALS)

Name _____ Birthdate _____/_____/_____

Address_____

City _____ State _____ Zipcode _____

Cell #_____ Home #_____

Darshana Novick D.D.S., M.S.
7351 W North Ave River Forest, IL 60305

Dental History

Name of Dentist:_____ Last Visit: _____

In your words, what is the orthodontic concern?_____

Have you had any previous orthodontic treatment or consultation? ❑ Yes ❑ No

If so, what work was completed, and by whom?_____

Has any other family member had orthodontics?_____

If so, what work was completed and by whom?_____

Were the results acceptable? ❑ Yes ❑ No

Has there every been a history of:

Clenching and/or grinding teeth during the day	❑ Yes	❑ No
Clenching and/or grinding teeth during sleep	❑ Yes	❑ No
Muscular soreness around head and neck	❑ Yes	❑ No
Pain or discomfort in the jaw joints	❑ Yes	❑ No
Jaw joints popping or clicking	❑ Yes	❑ No
Jaw joints locking open or closed	❑ Yes	❑ No
Difficulty on opening and closing mouth	❑ Yes	❑ No
Pain in front of ear or ear pain	❑ Yes	❑ No
Ringing in the ears	❑ Yes	❑ No
An adverse reaction during a medical or dental procedure	❑ Yes	❑ No
Serious trauma or injury to the teeth, face, jaws or head	❑ Yes	❑ No
When biting teeth together, my bite feels uncomfortable	❑ Yes	❑ No

Other information that may be helpful: _____

Do you exhibit any of the following speech problems:

Tongue Tied	❑ Yes	❑ No
Problems sounding letters	❑ Yes	❑ No
Seeing a speech pathologist	❑ Yes	❑ No

Other information that may be helpful: _____

Do you have any of the following habits:

Thumb or finger sucking	❑ Yes	❑ No
Breathing through mouth while awake	❑ Yes	❑ No
Tongue biting/chewing	❑ Yes	❑ No
Cheek biting/chewing	❑ Yes	❑ No
Lip biting/chewing	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No

Will you best describe your attitude toward orthodontic treatment:

❑ Wants treatment ❑ Treatment is necessary ❑ Unwilling, but agrees ❑ Uncooperative

Patient's Medical History

Are you under the care of a physician for any specific condition? ❑ Yes ❑ No

If yes, please describe_____

Are you taking any medication? ❑ Yes ❑ No

If yes, please list_____

Any Drug Sensitivity or Drug Allergies? ❑ Yes ❑ No

If yes, please explain _____

Have you ever received blood transfusion? ❑ Yes ❑ No

If yes, please explain reason for blood transfusion _____

Any major or unusual illnesses? ❑ Yes ❑ No

If yes, please explain _____

Are there any special considerations that we need to be aware of? ❑ Yes ❑ No

If yes, please explain _____

Please check if you have had any of the following:

❑ Heart Murmur	❑ Anemia	❑ Blood Disease
❑ Herpes	❑ Jaundice	❑ Tuberculosis
❑ Tonsillitis	❑ Bone Disorders	❑ Difficulty breathing
❑ Heart Disease	❑ Polio	❑ Allergic to Latex
❑ Prolonged Bleeding	❑ Diabetes	❑ Hepatitis
❑ Frequent Colds or Flu	❑ Rheumatic/Scarlet Fever	❑ Problems while asleep
❑ Rheumatism or Arthritis	❑ Frequent Fever Blisters	❑ Seasonal Allergies
❑ Any Thyroid Disease	❑ Any Respiratory Disease	❑ Bisphosphonates
❑ Endocrine or Growth Problems	❑ AIDS/HIV positive	❑ Asthma or hayfever
❑ Allergies	❑ Convulsions or Epilepsy	❑ Blood pressure problems
❑ Artificial joints or heart valves	❑ Headaches (more than normal)	❑ Tonsillitis

❑ Tonsils Removed? If checked, please list age when removed: _____

❑ Adnoids Removed? If checked, please list age when removed: _____

Are you pregnant or is there a possibility that you could be pregnant? ❑ Yes ❑ No

Have you currently been advised or have been advised in the past to take antibiotics? ❑ Yes ❑ No

Other Allergies present that were not mentioned above, please list: _____

Authorization

I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate.
I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there are any changes in my dental or medical status, I will inform Dr. Novick.

Signature_____Date_____