RAJA NASIR, D.D.S., M.S.D.

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Patient Information - Adult

Patient's Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ Male Female

Home Phone _____ Cell Phone _____ SS # _____

Home Address _____ City, State, ZIP _____
Street

Employer _____ Employer's Address _____

Occupation _____ How Long? _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? YES NO If YES, Name _____
First Middle Last

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

Have you visited an orthodontist before? YES NO If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? YES NO

Insurance Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Primary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Secondary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Dental and Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? YES NO If YES, please describe _____

Any sensitivities or allergies? YES NO If YES, please list _____

Currently taking any medications? YES NO If YES, please list _____ Amount/Dose _____

Have you been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	High Blood Pressure

Do you require antibiotics before dental treatment? YES NO If YES, explain _____

Have there been injuries to your face, mouth or chin? YES NO

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD) YES NO

Do/Did you have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Tongue Thrusting
Chronic Mouth Breathing	Speech Problems	Chewing/Eating Problems

Sleeping and Breathing Questions

Have you ever had or been diagnosed with any of the following:
Circle yes or no to each question please

Obstructive sleep apnea	YES	NO
Loud snoring	YES	NO
High blood pressure	YES	NO
Heart disease	YES	NO
Stroke	YES	NO
Diabetes	YES	NO
Thyroid hyper/hypo	YES	NO
Insomnia	YES	NO
Depression	YES	NO
COPD	YES	NO
Morning headache	YES	NO
Night time urination	YES	NO

Have trouble breathing or struggle to breathe	YES	NO
Sleep with your mouth open	YES	NO
Tend to breathe thru your mouth during the day	YES	NO
Wake up feeling UNREFRESHED	YES	NO
Wake up with headaches	YES	NO
Been diagnosed with Adult ADD or ADHD	YES	NO
Suffer from seasonal allergies	YES	NO
Take any allergy medication or nasal Spray on a regular basis	YES	NO
History of deviated septum or polyps diagnosed by an ENT	YES	NO
Suffer from chronic congestion	YES	NO
Unable to breathe thru nose	YES	NO

Thank you for taking the time to answer these questions. Being able to breathe properly can affect your teeth. This allows us to properly diagnose and correct malocclusion and any other issues associated.

Patient Name_____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature_____Date _____