NASIR ORTHODONTICS

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

1011 Augusta Dr Ste 203 • Houston, TX 77057
Phone: (713)781-4457

604 N. Winfree St. Dayton, TX 77535
Phone: (936) 258-3778

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

Nickname (if preferred) _____ Male Female Patient's Home Phone _____

Patient's Home Address _____ City, State, ZIP _____
Street

Who is filling in this form? Name _____
First Middle Last

Relationship _____ Do you have legal custody? YES NO

Patient's 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? _____

Has your child visited an orthodontist before? YES NO If YES, for what reason? _____

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

Parents Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Father

Father Step Father Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Address _____ Employer's # _____

If you have insurance coverage for the child, please fill out.

Insurance Company Name _____ Group or plan # _____

Insurance Company Phone # _____ Insurance Company Address _____

Mother

Mother Step Mother Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Address _____ Employer's # _____

If you have insurance coverage for the child, please fill out.

Insurance Company Name _____ Group or plan # _____

Insurance Company Phone # _____ Insurance Company Address _____

Dental and Medical History

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

Child's 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 _____

Has Puberty Begun? YES NO

Has menstruation (period) begun? YES NO NOT APPLICABLE

Has the child been treated for any of the following?

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

Does the child require antibiotics before dental treatment? YES NO If YES, explain _____

Have the adenoids or tonsils been removed? YES NO

Have you been informed of any missing or extra permanent teeth? YES NO

Have there been injuries to the child's face, mouth or chin? YES NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD) YES NO

Does/Did the child have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Prolonged Bottle/Pacifier
Mouth Breather	Speech Problems	Chewing/Eating Problems

Sleeping and Breathing Questions

Below are a few important questions that will aid us in properly identifying habits that can affect treatment results, during his or her orthodontic evaluation today.

Please answer the following questions with yes or no to the best of your knowledge.

When sleeping does your child:

Snore more than half the time? _____

Always snore? _____

Snore loudly? _____

Have "heavy" or loud breathing? _____

Have trouble breathing, or struggle to breathe? _____

Have you ever seen your child stop breathing during the night? _____

Sleep with his/her mouth open? _____

Does your child:

Tend to breathe thru his/her mouth during the day? _____

Have a dry mouth on wakening in the morning? _____

3. Occasionally wet the bed? _____

4. Wake up feeling UNREFRESHED in the morning? _____

5. Have a problem with sleepiness during the day? _____

6. Have a teacher or other supervisor commented that your child appears sleepy during the day? _____

7. Hard to wake up in the mornings? _____

8. Wake up with headaches in the morning? _____

9. Stop growing at a normal rate at any time since his birth? _____

I0. Is your child overweight? _____

11. Has he/she ever been diagnosed with ADD or ADHD? _____

Does your child often:

1. Not seem to listen when spoken to directly? _____

2. Have difficulty organizing task and activities? _____

3. Easily distracted by extraneous stimuli? _____

4. Fidgets with hands or feet or squirms in seat? _____

5. "On the go" or often acts as if "driven by a motor?" _____

6. Interrupts or intrudes on others (e.g. butts into conversations or games)? _____

Does your child:

1. Suffer from seasonal allergies? _____

2. Have any history of deviated septum or polyps Diagnosed by an ENT? _____

3. Take any allergy medication or nasal spray on a regular basis? _____

4. Suffer from chronic congestion? _____

5. Seem unable to breathe thru his/her nose? _____

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 _____