

Dr. Gordon Niles, DDS, MS

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Patient Number _____

Date _____

PATIENT INFORMATION

Name: _____ D.O.B. _____ Age: _____ M F
First Mi Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____ *Circle best contact option*

FATHER / GUARDIAN / SELF

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____
 Cell or Work Phone: _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

If there is Orthodontic Insurance Benefit, we need the following information filled out.

Social Security Number / ID#: _____

Group Number, if available: _____

Local or Union #: _____

Name of Employer: _____

Name of Insurance Company: _____

Insurance Co. Address: _____

City/State/Zip Code: _____

If Employed by Ford/GM: Salaried Hourly

MOTHER / GUARDIAN / SPOUSE

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____
 Cell or Work Phone: _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

If there is Orthodontic Insurance Benefit, we need the following information filled out.

Social Security Number / ID#: _____

Group Number, if available: _____

Local or Union #: _____

Name of Employer: _____

Name of Insurance Company: _____

Insurance Co. Address: _____

City/State/Zip Code: _____

If Employed by Ford/GM: Salaried Hourly

Who is the responsible party: _____

Dentist's Name: _____

Address: _____

Phone: _____

Who may we thank for referring you? _____

Other Children _____ D.O.B. _____

Other Children _____ D.O.B. _____

Other Children _____ D.O.B. _____

MEDICAL INFORMATION - DO YOU HAVE OR HAVE YOU EVERY HAD...

Heart Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Polio:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Respiratory Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Premedicate:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any Broken Bones: ..	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Type A B C (circle)		Prolonged Bleeding: .	<input type="checkbox"/> YES <input type="checkbox"/> NO
Thyroid Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yellow Jaundice:	<input type="checkbox"/> YES <input type="checkbox"/> NO
H.I.V. Positive:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Anemia:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation Therapy: ...	<input type="checkbox"/> YES <input type="checkbox"/> NO
Venereal Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Chemical Therapy: ...	<input type="checkbox"/> YES <input type="checkbox"/> NO
Intestinal Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Emphysema:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Transfusions: ..	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bone Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mononucleosis:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Latex Allergy:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nervous/Emotional Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hay Fever:	<input type="checkbox"/> YES <input type="checkbox"/> NO
ADHD	<input type="checkbox"/> YES <input type="checkbox"/> NO				
High or Low Blood Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Endocrine Problems:	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Renal/Kidney Disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Problems with Wounds Healing:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is the Patient Allergic to Anything? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Tumors or Cancer:	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, explain: _____			
Rheumatic/Yellow/Scarlet Fever:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Acquired Immune Deficiency Syndrome (AIDS):	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Is Patient Under Medical Care:	<input type="checkbox"/> YES <input type="checkbox"/> NO	List Any Medications Being Taken: _____			
A History of Fainting or Dizziness:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
A Drug Addiction:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Is the Patient Pregnant at this Time:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Measles/Mumps/Chicken Pox:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you aware of Any Other Disease, Condition, or Problem not listed above that			
Does the Patient Smoke:	<input type="checkbox"/> YES <input type="checkbox"/> NO	We Should Know About? _____			
Is the Patient in Good Health:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Is Height and Weight Normal for Age:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Fever Blisters:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Has the Patient Had a Physical this Year:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			
Has the Patient Reached Puberty:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are immunizations up to date? <input type="checkbox"/> YES <input type="checkbox"/> NO			

DENTAL HISTORY

Has the Patient Seen a General Dentist in the Last Year: ..	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the Patient Have or Ever Had Any of the Following Habits:	
Any Pain, Clicking or Discomfort In or Near the Ear:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gag Reflex	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the Mouth, Face or Teeth Been Injured by a		Cheek, Tongue or Lip Chewing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fall or Accident:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thumb Sucking: <input type="checkbox"/> present <input type="checkbox"/> past	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have You Been Informed of Missing or		Mouth Breathing:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Extra Permanent Teeth:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Finger Nail Biting:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are You aware of Any "Gum" Problems:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Clenching Teeth:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has a Physician or Dentist Advised Antibiotics		Tongue Thrusting:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Before Dental Exam:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Grinding Teeth:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have the Patient's Tonsils or Adenoids Been Removed: .	<input type="checkbox"/> YES <input type="checkbox"/> NO	Speech Problems:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do You Feel the Patient Can Benefit from.....		Has the Patient Been Examined by an Orthodontist Before: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Orthodontic Treatment:	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when: _____	
Is the Patient Happy with His/Her "SMILE":	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is this a second opinion?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the Patient Want to Improve His/Her "SMILE"		Have other Members of the Family had	
and "BITE":	<input type="checkbox"/> YES <input type="checkbox"/> NO	Orthodontic Treatment:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Would the Patient Mind Wearing "BRACES"	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, were you happy with the results: _____	
Are you allergic to any metals or dental materials	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why: _____	

In your own words, What Is The Orthodontic Problem: _____

What Would You Like Orthodontic Treatment To Accomplish? _____

Patient Signature

Date

Parent Signature