ARCADIA ORTHODONTICS
Matt N. Nashed, D.D.S, M.S.

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Welcome to our office. Please take a few minutes and complete this medical history so that we can serve you better.

Patient Information

Last Name:_________________________ First Name:___________________________ M.I.____
Address:____________________________________ City________________________________
State:_________________ Zip Code:________________ Birthday ______________________
Social Security Number____________________________ Home Phone#___________________
Sex: M / F e-mail_______________________________ Cell Phone#_____________________

Financial Responsible Party

Last Name:________________________ First Name:_____________________________ M.I.____
Address:____________________________________ City:________________________________
State:_________________ Zip Code:________________ Telephone#______________________
Social Security Number____________________________ Birthday________________________
Employed by_____________________________________ Drivers License#________________
Employer Address_____________________________ City:______________________________
State:_________________ Zip Code:________________ Work Phone#____________________

Who may we thank for referring you to our office?_____________________________________
Dentist Name_______________________________ Phone #______________________________
Physician's Name____________________________ Phone#______________________________

Do you have orthodontic insurance? _______Yes _______ No

Insurance Company________________________________ Phone #_______________________
Policy Holders Social Security Number__________________________ Group#______________
Policy Holders Name________________________________ Birthday______________________

DENTAL HISTORY

Have there been any injuries to your face, mouth or teeth?____________________Yes No
Has the patient ever sucked a thumb or fingers? Until what age?________________Yes No
Does patient have any speech problems?____________________________________ Yes No
Is patient a mouth breather? ____Yes No
If Yes, please check one _______Daytime ________Sleep ____________All the time
Last visit to family dentist:______________ Was Cleaning done? ____Yes ___No
Does patient have any jaw pain, clicking or discomfort in the TMJ (jaw joints)_____Yes No
If patient had braces before, please indicate approximate duration of treatment_______________
Year completed:____________
If this is a transfer case, Name of Doctor:__________________When started________________
Date of last visit_____________________

MEDICAL HISTORY

Is the patient in good health?____Yes No
Is the patient currently under a physicians care?_____________________________Yes No
If Yes, please explain:____
Is the patient taking any medication?_______________________________________Yes No
Is the patient allergic to any medication?___________________________________ Yes No
Is the patient allergic to latex?____ Yes No
Has the patient ever taken Fen-Phen?_______________________________________ Yes No
Has the patient ever been hospitalized?_____________________________________ Yes No
Has the patient ever had surgery?____Yes No

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE YES OR NO)

Anemia	yes	no	Head injuries	yes	no	Blood transfusion	yes	no
Herpes	yes	no	Hear failure	yes	no	Nervous disorder	yes	no
Strokes	yes	no	Liver disease	yes	no	Psychiatric treatment	yes	no
Ulcers	yes	no	Scarlet fever	yes	no	Tumors	yes	no
Diabetes	yes	no	Chicken pox	yes	no	Allergies or hives	yes	no
Glaucoma	yes	no	Sinus Trouble	yes	no	Asthma	yes	no
Allergies	yes	no	Arthritis	yes	no	Prolonged bleeding	yes	no
Cold sores	yes	no	Blood disease	yes	no	Congenital heart disease	yes	no
Epilepsy	yes	no	Heart murmur	yes	no	Bruise easily	yes	no
Seizures	yes	no	Heart attack	yes	no	Difficulty swallowing	yes	no
Hepatitis	yes	no	A.I.D.S.	yes	no	H.I.V. positive	yes	no
Cancer	yes	no	Thyroid disease	yes	no	Cerebral Palsy	yes	no
Tumors	yes	no	Convulsions	yes	no	Hearing problem	yes	no

Other______________

If you have answered yes to any of the above questions, or feel that there is anything else we should be aware of please explain:____

____

____

What is your primary reason for seeking orthodontic treatment?___________________________________

____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in the patient’s medical status.

Signature of patient or legal representative____________________________ Date_____________

Signature of Dentist____ Date_____________