RUCHI NANDA D.D.S., M.S., PC
ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS
CHILDREN*TEENS*ADULTS

17200 N. May Ave., #300
Edmond, OK 73003
(405) 330-9911

Patient Information

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birth date_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office? _____

Name of your dentist_____ School Attending_____

Responsible Party Information

Name_____ _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Cell Phone_____

Work Phone _____ E-mail Address _____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Employer Address_____
Street City State Zip

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Employer Address_____
Street City State Zip

Social Security #_____ Birth date_____ Cell Phone _____

Work Phone _____E-Mail Address _____

Dental Insurance Information

Insured's Name_____ Insured's Soc. Sec. #_____

Insurance Company_____ ID No._____ Ins. Phone No._____

Insurance Co. Address_____
Street City State Zip

Do you have dual coverage? Yes No If yes:

Insured's Name_____ Insured's Soc. Sec. #_____

Insurance Co._____ ID No._____ Ins. Phone No._____

Insurance Co. Address_____
Street City State Zip

Insured Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone Number _____ Phone Type _____

I understand that when appropriate, credit bureau reports may be obtained. Permission is given to text and e-mail for office reminders.

Signature (Parent's signature if patient is under 18 years of age.)_____

HEALTH HISTORY

Date of Exam: _____/_____/20_____
Date of Birth: _____/_____/_____

Patient's Name: _____ **Age**: _____ **Sex**: Male Female
Last First Middle Initial

Dental History

Yes No Has patient ever sucked thumb or fingers? Until what age?____
Yes No Does patient breath predominately through the mouth?
Yes No Does patient have any speech problems?_____
Yes No Does patient clench or grind teeth (day or night)?
Yes No Does patient have pain or clicking upon closing mouth?
Yes No Has patient had any severe head or face injuries?
Yes No Have any teeth been injured or chipped due to accidents?
Yes No Has patient ever had any abscessed teeth?
Yes No Has patient been informed of missing permanent teeth?
Yes No Has patient been informed of any extra teeth?
Yes No Were any teeth (baby or permanent) removed by extraction?
Yes No Have X-rays of teeth been taken? If so, when?_____

Yes No Was it suggested that the space be maintained?
Yes No Was an appliance placed to maintain the space?
Yes No Is patient taking fluoride drops, pills or fluoridated water?
Yes No Have the teeth been treated with fluorides?
Yes No Does patient see dentist regularly? Date of last visit:____
Yes No Any previous orthodontic consultation or treatment?
Yes No Does patient resemble mother and/or father?
Yes No Is patient adopted? At what age?_____
Yes No Does anyone in family have similar dental condition?
Yes No Would patient mind wearing "braces"?
Yes No Any noticeable difficulty in chewing or swallowing food?
Of full mouth? **Yes No**

Medical History

Date of last physical:___/___/___
Have you ever had any of the following?

Yes No Heart Problems
Yes No High Blood Pressure
Yes No Low Blood Pressure
Yes No Circulatory Problems
Yes No Nervous Problems
Yes No Radiation Treatment
Yes No Special Diet
Yes No Swollen Neck Glands
Yes No Rheumatic Fever
Yes No Sinus Problems
Yes No Artificial Heart Valves or Joints
Yes No Recent Weight Loss
Yes No Back Problems
Yes No Diabetes
Yes No Respiratory Disease
Yes No Epilepsy
Yes No Headaches__times per week
Yes No Stroke
Yes No Ulcer
Yes No Chemical Dependency
Yes No Hepatitis, Jaundice, or Liver Disease
Yes No Hemophilia
Yes No Cancer
Yes No Psychiatric Care
Yes No Chronic Diarrhea
Yes No Allergies to Anesthetics
Yes No Allergies to Medicine or Drugs
Yes No General Allergies
Yes No Blood Disease
Yes No Arthritis
Yes No Venereal Disease
Yes No Pregnant
Yes No "A.I.D.S." or Other Immunosuppressive Disorders

Do you have any drug allergies or have you ever had an adverse reaction to any medication? **Yes No** If so, to what?_____
Have you ever responded adversely to medical or dental treatment? **Yes No** Explain:_____
Are you taking any medication at this time? **Yes No** If so, what?_____
Are you under the care of a physician? **Yes No** If so, for what conditions?_____
If patient is a child, what is his/her weight?_____ pounds
Is there anything else we should know about your medical history?_____
Women Only: Do you suspect that you are pregnant? **Yes No** If so, are you nursing? **Yes No**

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY ORTHODONTIST OR ANY MEMBER OF HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. FURTHER, I HEREBY AUTHORIZE RUCHI NANDA, D.D.S., M.S., PC TO OBTAIN ANY INFORMATION THAT MAY BE REQUIRED FOR CREDIT ACCEPTANCE.

THE POLICY IN OUR OFFICE IS THAT THE PARENT WHO REQUESTS TREATMENT IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.

_____ _____ _____
Patient's Signature Parent's Signature (Required if Patient is under 18 years of age) Date