Norman J. Nagel DDS, MS, INC
Jeffrey N. Nagel DDS, MS
ORTHODONTICS
Because a Smile is Forever

WELCOME

1 Patient Information

Date: ________ DOB: ________ Age: _____ Sex:M / F
Patient's Name: ______________________________
Last *First* *MI*
Address: ______________________________
____
City *State* *Zip*
Hm #: ____________ Cell#: ____________
Pt. Email: ______________________________
Dentist, City: ______________________________
School: ______________________________
Hobbies: ______________________________
List Siblings with age: ______________________________
____
Your name & relationship to patient: ____________
Whom may we thank for referring you? ____________

2 Patient Dental History

What are the main concerns you would like orthodontics to accomplish? ______________________________
____
Have you ever been evaluated for orthodontics? Y N
Do you like your smile? Y N
Ever had serious problems with previous dental work? Y N
Do you have any missing or extra permanent teeth? Y N
Ever had, or have, pain or discomfort in the jaw joint? Y N
Your current dental health is: Good Fair Poor
Have you ever had an injury to your: Mouth Teeth Chin
Circle any of the following that is or has ever been true of you:

Thumb Sucking	Smoker
Nail Biting	Gums Bleed / Itch
Tongue Sucking / Thrusting	Mouth Breather
Lip Sucking / Biting	Speech Problems
Only Chew on One Side	Taken Phen-Fen
Hurts to Chew	Adenoids or tonsils removed

When was your last dental visit? ____________

3 Responsible Party Information

(If different from Section 1)

Name: ______________________________
Relation: ____________ DOB: ____________
Billing Address: ______________________________
____
City *State* *Zip*
Wk #: ____________ Cell#: ____________
Rsp. Email*: ______________________________
Occupation: ______________________________
Employer: ____________ Yrs: ______
Spouse Name: ______________________________
Relation: ____________ DOB: ____________
Wk #: ____________ Cell#: ____________
Occupation: ______________________________
Employer: ____________ Yrs: ______

4 Insurance Information

Insured Name: ______________________________
Relationship to patient: ______________________________
DOB: ____________ SS#: ____________
Insured's Employer: ______________________________
Ins. Company: ______________________________
Group No. ______________________________
Ins. Address: ______________________________
Ins. Phone: ______________________________
Do you have dual coverage? Y / N
Insured Name: ______________________________
Relationship to patient: ______________________________
DOB: ____________ SS#: ____________
Insured's Employer: ______________________________
Ins. Company: ______________________________
Group No. ______________________________
Ins. Address: ______________________________
Ins. Phone: ______________________________

5 Emergency Information

Name of nearest relative or neighbor: ____________
Relation: ____________ Ph #: ____________
Address: ______________________________
____
City *State* *Zip*

**Primary email notification*

Park Plaza • 3695 Alamo St., Ste. 301 • Simi Valley, CA 93063 • (805)581-2480
Duesenberg Dental Square • 47 Duesenberg Dr., Ste. 202 • Thousand Oaks, CA 91362 • (805) 496-5114

6

Patient Medical History

Physician Name: ______________________ Phone: ______________________

Address: ____

Street *City* *CA* *Zip*

Your current physical health is: Good Fair Poor When was your last physical? ____________

Have you ever experienced any of the following symptoms or procedures? (Circle Yes or No):

Abnormal Bleeding	Y	N	Frequently Nervous	Y	N	Sleep Deprivation from Pain	Y	N
Anemia	Y	N	General or Local Anesthetic	Y	N	Stomach trouble	Y	N
Arthritis	Y	N	Head X-ray / Radiation Therapy	Y	N	Frequent Sore Throats	Y	N
Asthma	Y	N	Heart trouble	Y	N	Frequent Toothaches	Y	N
Back / Neck Pain	Y	N	Hepatitis	Y	N	Seizures	Y	N
Blood Disorder	Y	N	High Blood Pressure	Y	N	Short of Breath Easily	Y	N
Chicken Pox	Y	N	Hives or Skin Rash	Y	N	Stroke	Y	N
Depression	Y	N	Jaundice	Y	N	Surgery / Operation	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Swollen Ankles	Y	N
Dizzy Spells	Y	N	Lung Disease	Y	N	Syphilis / Gonorrhea	Y	N
Drink Alcohol Daily	Y	N	Kidney / Bladder Trouble	Y	N	Tired Jaw After Chewing	Y	N
Ear Pain	Y	N	Measles	Y	N	Thyroid Disease	Y	N
Easily Upset	Y	N	Mumps	Y	N	Tuberculosis	Y	N
Epilepsy	Y	N	Rheumatic Fever	Y	N	Ulcers	Y	N
Frequent / Severe Headaches	Y	N	Sinus Problems	Y	N	Venereal Disease	Y	N

Please elaborate on any of the above, where necessary: ____________________________

____

List any serious medical condition(s) you have had, NOT listed above: ____________________

____

GIRLS Has menstruation begun? Y N | BOYS Has puberty begun? Y N

WOMEN Are you pregnant? Y N | Are you currently in, or have you passed through menopause? Y N

Has there been any change in your health in the last year, including considerable weight loss & gain? Describe.

____

Other than corrective glasses, have you ever been treated for eye or ear trouble? Y N

7

Allergies

Is the patient sensitive or allergic to any of the following?

Aspirin	Y	N	Erythromycin	Y	N	Penicillin	Y	N
Codeine	Y	N	Latex	Y	N	Plastics	Y	N
Dental Anesthetics	Y	N	Metals	Y	N	Tetracycline	Y	N

Please list any other drugs / materials that you are allergic to: ____________

____

8

Drugs & Medications

Please list all prescription and non-prescription drugs taken or used in the past three months: ____________

____

____

____

9

Thank you for filling out this form completely.

By signing, I agree that information I have given today is correct to the best of my knowledge. I also understand that this information is held in the strictest confidence, as described in the Notice of Privacy Practices given to me. I recognize that it is my responsibility to inform this office of any changes in my medical status. I understand that when appropriate, credit bureau reports may be obtained. Furthermore, I authorize this staff to perform any necessary dental services that I may need during diagnosis and treatment *with my informed consent.*

____________________ ____________________ ____________________

Responsible Party Name *Signature* *Date*

Office Use	Medical / dental information reviewed with patient named herein.	Initials:	Date:

© Norman J. Nagel D.D.S., M.S., Inc.
NPForm.TO.CN