Nia
Pediatric Dentistry
& Family Orthodontics

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us we will be more than happy to help.

Patient's Information

Name: _____Nickname: _____ Sex: (M) (F)
Birthdate: _____
Purpose of visit: _____
How can we help to improve your smile:_____
Home Address: _____
Home Phone#:(_____)_____ Cellular Phone:(_____)_____Work Phone:(_____)_____
Occupation:_____ Employer: _____
Business Address: _____
How would you like us to contact you? Home_____ Work _____Cell_____ E-mail_____

Emergency Contact:_____ Relationship _____
Address: _____ Phone:(_____)_____

Who may we thank for referring you to us? _____

Insurance Information

Do you have dental insurance coverage? Y N

Primary Insurance Company: _____
Group Number: _____
Address of Primary Company: _____

Secondary Insurance Company: _____
Group Number_____
Address of Secondary Insurance Company: _____

Health History

Primary Care Provider: _____Phone number: (_____)_____
Last Physical: _____
Are you under a physician's care now? Y N If yes, reason: _____
Are you currently taking any medications (including over the counter)? Y N
If yes, please list: _____
Are you allergic to any medication? Y N
If yes, please list: _____
Any history of hospitalization or surgery: Y N
if yes, please explain:_____

Do you have allergic reaction to: (if yes: please check all that applies)

___ Peanuts/ Tree nuts ___ Soy ___ Latex/ Rubber ___ Pollen/ Dust/ Environmental ___ Anesthetics
___ Eggs ___ Metals ___ Animals ___ Berries ___ Acrylic ___ Milk ___ Wheat/Gluten ___ Dyes/Coloring
Others: _____

Have you had a history or difficulty with any of the following?

ADHD/ADD Y N	Cardiac Disease/Heart Y N	Hepatitis Y N
Anemia Y N	Cerebral Palsy Y N	Immune Disorder Y N
Allergies Y N	Chemo/Radiation Therapy Y N	Kidney Y N
Arthritis/Joint Disorder Y N	Cystic Fibrosis Y N	Liver Y N
Asthma Y N	Delayed Development Y N	Murmur Y N
Allergies to Medications Y N	Depression/Anxiety Y N	Muscular Disorder Y N
Autism Y N	Diabetes Y N	Premature Birth Y N
Bladder Y N	Down's Syndrome Y N	Rheumatic Fever/Heart Y N
Bleeding Disorder Y N	Earaches/Infections Y N	Speech Disorder Y N
Bone Disorder Y N	Eating Disorder Y N	Sinusitis Y N
Brain Injury Y N	Emotional/School Problems Y N	TMJ Problems Y N
Bruising Y N	Epilepsy/Seizure Y N	Tuberculosis Y N
Cancer/Malignancy Y N	Hearing Impaired Y N	Visual Impaired Y N

Other: _____
If yes, please explain: _____
_____

Dental/Orthodontic History

Are you currently under care of a dentist? Y N
If yes, Dentist's name _____ Phone number: (_____)_____
Date of last visit: _____ Were any x-rays taken? Y N

Is this your first visit with an orthodontist? Y N
If no, previous orthodontist: _____ Phone number:(_____)_____
Date of last visit: _____ Were any x-rays taken? Y N

Have you had any injuries to teeth, mouth, or head? Y N
If yes, please describe: _____

Have you done any of the following (past or present)?
Please circle: thumb/finger-sucking____ nail biting_____ lip sucking_____ mouth-breathing_____ snoring
teeth grinding _____

Do you use fluoridate toothpaste? Y N
How often do you brush your teeth? _____
How often do you floss? _____
How may we help to make this visit a positive experience for you?
_____

I understand that the information I have given 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 the office of any changes in my health status.

SIGNATURE:_____ Date:_____

Financial Agreement

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to Nia Dentistry LLC. I understand I am financially responsible for any charges not covered by my insurance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand that it is my responsibility to provide accurate and complete insurance information so Nia Dentistry LLC may assist me in filing my claim promptly. I will be required to pay my portion the day of dental treatment. I understand that if my insurance company denies any the claims, I am responsible for the full payment.

For patients without insurances: I understand that payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services.

SIGNATURE:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

SIGNATURE:_____ Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communications barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other (Please Explain):_____
_____

Initials_____ Date_____