Anuja Kothari, D.D.S., M.S.
www.northwestorthodontics.com

NORTHWEST ORTHODONTICS

Name	Nickname		Sex
Birthdate	Age		Home Phone
Address			Secondary Phone
City	State	Zip	Email
Dentist	Physician		

How did you hear about our office?

Has the patient received an evaluation or treatment in another Orthodontic Office? ☐ Y ☐ N

If Yes, by whom?

What questions would you like answered today?

COMPLETE FOR A CHILD PATIENT:

School	Grade	Musical Instrument	
Sports	Hobbies/Interests		
Father's Name	Home Phone	Work Phone	
Address	City	State	Zip
Employer			
Mother's Name	Home Phone	Work Phone	
Address	City	State	Zip
Employer			

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Mother ☐ Step Mother ☐ Guardian

Name(s) and ages of other children in family

Name(s) of your other children seen in this office

COMPLETE FOR AN ADULT PATIENT:

Your Employer	Work Phone	
Spouse's Name	Employer	Work Phone

Women: Are you pregnant or trying to become pregnant?

DENTAL INSURANCE INFORMATION: (Please use information from your insurance card to complete this section.)

Primary		**Secondary**	
Ins. Co.		Ins. Co.	
Address		Address	
City/St./Zip		City/St./Zip	
Phone #		Phone#	
Insured		Insured	
SS#	Birthdate	SS#	Birthdate
Group #		Group #	
Employer	ID#	Employer	ID#

Person(s) responsible for payment & relationship to patient:

OVER FOR MORE INFORMATION

9731 W. Grand Avenue
Franklin Park, IL 60131
(847) 455-4664
(847) 455-9310 Fax

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820 S. Bartlett Road
Streamwood, IL 60107
(630) 830-9700
(630) 830-9739 Fax

MEDICAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (Check YES or NO)

AIDS	☐Y ☐N	Diabetes	☐Y ☐N	HIV Infection	☐Y ☐N
Anemia	☐Y ☐N	Emotional Problems	☐Y ☐N	Kidney Disorders	☐Y ☐N
Arthritis	☐Y ☐N	Endocrine Disorders	☐Y ☐N	Latex Sensitivity	☐Y ☐N
Artificial Heart Valve	☐Y ☐N	Epilepsy (Convulsions)	☐Y ☐N	Liver Disease	☐Y ☐N
Artificial Joints	☐Y ☐N	Frequent Headaches	☐Y ☐N	Mitral Valve Prolapse	☐Y ☐N
Asthma	☐Y ☐N	Glaucoma	☐Y ☐N	Neurologic Disorders	☐Y ☐N
Blood Disorders	☐Y ☐N	Heart Murmur/Heart Problems	☐Y ☐N	Respiratory Problems	☐Y ☐N
Blood Transfusions	☐Y ☐N	Hemophilia	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Bruise Easily	☐Y ☐N	Hepatitis	☐Y ☐N	Thyroid Problems	☐Y ☐N
Cerebral Palsy	☐Y ☐N	Herpes	☐Y ☐N	Tonsil / Adenoid Removal	☐Y ☐N
Congenital Heart Disease	☐Y ☐N	High Blood Pressure	☐Y ☐N	Tuberculosis	☐Y ☐N

STATE ANY REASONS WHY THE PATIENT IS CURRENTLY UNDER THE CARE OF A PHYSICIAN _____

_____

LIST ANY MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING _____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES _____

_____

HAS THE PATIENT BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES? (YES or NO) _____

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE _____

_____

DEVELOPMENTAL HISTORY

PATIENT'S HEIGHT _____ PATIENT'S WEIGHT _____ FATHER'S HEIGHT _____ MOTHER'S _____

HAS PATIENT REACHED PUBERTY? _____ IF YES, WHEN? _____

IS PATIENT ADOPTED? _____

DENTAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (Check YES or NO)

Bleeding Gums	☐Y ☐N	Jaw Joint Pain	☐Y ☐N	Nail Biting	☐Y ☐N
Chronic Facial Pain	☐Y ☐N	Jaw Joints Pop or Click	☐Y ☐N	Periodontal Surgery	☐Y ☐N
Clenching or Grinding of Teeth	☐Y ☐N	Jaw Locking Open or Closed	☐Y ☐N	Perm. Teeth Removed	☐Y ☐N
Difficulty Chewing/Swallowing	☐Y ☐N	Limitation in Mouth Opening	☐Y ☐N	Speech Problems	☐Y ☐N
Dizziness	☐Y ☐N	Missing/Extra Permanent Teeth	☐Y ☐N	Sucks Thumb, Finger or Lip	☐Y ☐N
Frequent Headaches	☐Y ☐N	Mouth Breathing	☐Y ☐N	Teeth Sensitivity - Hot/Cold	☐Y ☐N
Injuries to Face or Teeth	☐Y ☐N	Muscle Tenderness in Jaw/Neck	☐Y ☐N	Tongue Thrust	☐Y ☐N

DATE OF LAST VISIT _____

LIST ANY DENTAL PROBLEMS WE SHOULD KNOW ABOUT _____

LIST THE PATIENT'S CHIEF CONCERNS AND WHAT THEY WOULD LIKE THIS ORTHODONTIC TREATMENT TO ACCOMPLISH

_____

_____

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental insurance. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Kothari and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment. I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____ **DATE** _____

FOR OFFICE USE
UPDATES (DATE AND INITIAL)

DOCTOR SIGNATURE _____ **DATE** _____