Greater Reston Herndon Orthodontics
Jina Naghdi, D.D.S., M.S., P.C.

Patient Information

Date _____ Nick Name _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Soc. Sec. # _____

Patient's Dentist _____ Oral Surgeon _____

Patient's School _____

Names & ages of other children in the family _____

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

How did you hear of our office? _____

Responsible Party Information

Name _____ Relationship to Patient _____
Last First Middle

Address _____
Street City State Zip

Mailing Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Soc. Sec. # _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Email Address _____ Soc. Sec # _____ Birthdate _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # or ID _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # or ID _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____ Insured's Employer _____

Medical History

Is patient in good health? _____ Yes No

Does patient have any history of major illness? _____ Yes No

Has the patient ever been under the care of a physician for illness? _____ Yes No

Please List _____

Check any of the following for which the patient has been treated:

Diabetes	☐	Tuberculosis	☐	Endocrince Problems	☐
Pneumonia	☐	Anemia	☐	Prolonged Bleeding	☐
Heart Trouble	☐	Epilepsy	☐	Fainting & Dizziness	☐
Rheumatic Fever	☐	Asthma	☐	Nervous Disorders	☐
Bone Disorders	☐	Kidney Involvement	☐	Liver Involvement	☐
High Blood Pressure	☐	Hepatitis	☐	Venereal Disease	☐
Blood Transfusion	☐	Emotional Problems	☐	HIV Positive/Aids	☐
Tendency to colds	☐	Sore Throats	☐	Ear Infections	☐

Have tonsils and adenoids been removed? What age? _____ Yes No

List and drugs or medications now being taken. Give reasons _____

_____

List any allergies or drug sensitivity _____

Has the patient reached puberty? Girls - has she started menstruation _____ Yes No
Boys - has his voice changed _____ Yes No

Height _____ Weight _____

Dental History

Does the patient need to be pre-medicated for dental treatment due to a medical condition? ___ Yes No

Has there been any injury to the face, mouth or teeth? _____ Yes No

Has the patient ever sucked a thumb or fingers? Until what age? _____ Yes No

Does the patient have any speech problems? _____ Yes No

Is the patient a mouth breather? While awake? _____ Yes No

While asleep? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Are there any medical, dental or surgical problems not covered above? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

Has either parent had orthodontic treatment? _____ Yes No

List any musical instruments played _____

Reason for consultation _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Signature (Parent's signature if minor) _____ Date _____