RIDDER ORTHODONTICS

NICK RIDDER, DDS, MS

12453 TIMBERLAND BLVD. #101
KELLER, TX 76244

13100 NW HWY 287 #154
HASLET, TX 76052

T 817-741-0484
F 817-741-0489
INFO@RIDDERORTHODONTICS.COM

WWW.RIDDERORTHODONTICS.COM

NEW PATIENT INFORMATION CHILD

Today's Date:_____

Child's Name_____ Nickname _____
LAST FIRST MI

Home Address _____
Phone _____ School _____ Grade _____
Contact email_____
Date of Birth _____ Age _____ Sex: Female Male
List Sports & Interest of Patient _____
Patient's Dentist _____ Last visit date _____
Referred by _____
Patient Lives with: both parents mother father guardian
Father's Name _____ Employment _____
Work Phone _____
Mother's Name _____ Employment _____
Work Phone_____
Marital Status: married separated divorced remarried widowed single
Name & Ages of Children in family_____
_____
Main concern(s) for today's appointment: _____
_____
Does the patient want orthodontic treatment? _____

MEDICAL HISTORY

Diabetes	Y	N	Hay Fever	Y	N	HIV	Y	N
Heart Trouble	Y	N	Asthma	Y	N	Tonsillitis	Y	N
Rheumatic fever	Y	N	Allergies	Y	N	Hepatitis	Y	N
Bone disorders	Y	N	Convulsions	Y	N	Endocrine-thyroid	Y	N
Abnormal bleeding	Y	N	ADD/ADHD	Y	N	Epilepsy	Y	N

Any other medical concerns?

_____

List any drugs or medications currently taking:
_____ Why? _____
_____ Why? _____
Is the patient allergic to any medications? _____
Is the patient allergic to? LATEX METALS/NICKEL PLASTICS
Have tonsils and adenoids been removed? _____ Does patient snore?_____
Has the patient reached puberty? _____ Patient most resembles: Mother Father Both
Height: Patient _____ Mother _____ Father _____

Have there been any injuries to the face, mouth or teeth? _____
Did the patient ever suck thumb or fingers? _____ Until what age? _____
Does the patient have any problems with speech? _____
Does the patient play a wind musical instrument? _____ What kind? _____
Have you been informed of any missing or extra permanent teeth? _____
Has the patient had any previous orthodontic examinations? _____
Where any x-rays taken? _____
Is the patient especially apprehensive towards dental visits? _____
Does the patient have any congenital abnormalities? _____
Does the patient have any of the following habits? MOUTH BREATHER NAIL BITING
NURSING/BOTTLE HABITS LIP SUCKING/ BITING TONGUE THRUST

TMJ History

Has the patient had any discomfort or clicking in the jaw-joints near the ears? _____
Does the patient clench or grind his/her teeth? _____
Does the patient have frequent head or neck aches? _____
Does the patient have pain or ringing in the ears? _____
Has the patient's jaw ever locked or slipped out of place? _____
Are his/her teeth sore or sensitive? _____

Insurance Information

Person Responsible for Account _____
LAST FIRST MI
Relationship to Patient _____ Date of Birth _____
Address (if different than patient) _____
Home Phone _____ SS # _____
Employer _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ Insurance Phone _____
Insurance Company Address _____

I understand that the information that 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 this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

_____
Signature of parent or guardian Date

Doctor/Staff Signature _____ Date _____
Nick Ridder, DDS, MS