NILE A. SORENSON DMD
4915 YORBA RANCH RD., SUITE A
YORBA LINDA, CA 92887

(714) 777-4080

www.drnile.com

Emergency Phone # _____

Email _____

INFORMATION RECORD

Patient _____ Date _____
Last First Middle

Age _____ Birthday _____ Telephone _____
Month Day Year

Residence Address _____
Street City Zip

Full name of person responsible for patients financial account _____

Address _____ Social Security # _____

Occupation _____ Work telephone _____

Employer & Address _____

Patient's Dentist _____ city _____ date of last visit _____

Patient's physician _____ city _____

Insurance Co. or Group Covering Orthodontics _____

How did you find out about our office _____

	Check One Yes	No
1. Is the patient in good health? _____	☐	☐
2. Does the patient have regular medical examinations? _____	☐	☐
3. Is there any medical condition of which we should be aware? If yes explain _____	☐	☐
4. Has the patient had problems with or history of heart trouble, allergies, diabetes, asthma, kidneys, liver, epilipsy, or bleeding disorders? _____	☐	☐
5. Has the patient had any history of arthritis, AIDS, hepatitis, rheumatic fever, venereal disease, or congenital heart problems? (If answer is yes, circle condition) _____	☐	☐
6. Has the patient experienced any unfavorable reaction to medicine, such as Penicillin, novocain, aspirin, etc. _____	☐	☐
7. Is the patient currently taking any medication? If yes list _____	☐	☐
8. Is there a history of thumb or finger sucking? If yes explain _____	☐	☐
9. Does the patient have a habit of mouth breathing? _____	☐	☐
10. Is there an hereditary background that might contribute to the patient's dental problem? _____	☐	☐
11. Has the patient experienced pain, clicking or popping sounds in the jaw joint? _____	☐	☐
12. Has the patient been seen previously by an Orthodontist? _____	☐	☐
13. Describe the orthodontic problem in your own words. _____		

_____
Signature and Consent