Lynnette Nyberg DMD, MSD
51 Webb Place Suite 150
Dover, NH 03820
Ph: 603-749-2900

Patient's Name:______________________________

Date of Birth: ______________ Age: ______ Sex: _______ Social Security #: ______________________

Address, City, State, Zip: ______________________________

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________________

Employer: ______________________ Work Phone: ______________________

Responsible Party #1 (Spouse, Parent, Guardian, etc):______________________________

Relation to Patient: ______________________________

Address (if different from patient):______________________________

Cell Ph: ______________ Home Ph: ______________ Work Ph: ______________

Responsible Party #2 (Parent, Guardian, etc)______________________________

Relation to Patient: ______________________________

Address (if different from patient):______________________________

Cell Ph: ______________ Home Ph: ______________ Work Ph: ______________

Who referred you to our office? ______________________________

Please list any relatives seen by Dr. Nyberg: ______________________________

Who is your general dentist? ______________________ Date of last visit: ______________

Who is your physician? ______________________ Date of last visit: ______________

Dental Insurance

Policy Holder's Name:______________________ SSN: ______________________

Date of Birth: ______________________ Employer: ______________________

Insurance Company:______________ Group #:______________ ID #:______________

Ins. Co. Address:______________________ Ins. Co. Ph:______________

Medical History

Are you taking any medications? ____ Yes No

Do you have any allergies? ____ Yes No

Have you had any operations? ____ Yes No

Have you ever been involved in a serious accident? ______________________________ Yes No

Are you pregnant or trying to conceive? ________________________________ Yes No

Have you ever smoked or chewed tobacco? ______________________________ Yes No

Are there any other medical conditions we should be aware of? ______________________________

Circle any of the medical conditions below that you <u>have had</u> or <u>currently have</u>:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Dental History

What concerns you most about your teeth? ____

Are you presently in any dental pain? ________________________________ Yes No

Have you ever experienced any unfavorable reaction to dentistry?__________________ Yes No

Have you ever lost, chipped or had any teeth removed (incl. wisdom teeth)? ___________ Yes No

Have there been any injuries to face, mouth, or teeth? ______________________ Yes No

Is any part of your mouth sensitive to temperature or pressure?__________________ Yes No

Do your teeth or jaws ever feel uncomfortable when you wake in the morning? __________ Yes No

Are you aware of your jaw clicking or popping? ________________________ Yes No

Are you aware of clenching your teeth during the day? ______________________ Yes No

Have you ever been told that you grind your teeth? ______________________ Yes No

Do you have tension headaches? ________________________________ Yes No

Have you ever experienced chronic ringing in your ears? ____________________ Yes No

Do your gums bleed when you brush? ______________________________ Yes No

Do you have any type of thumb or tongue habit? __________________________ Yes No

Are you a mouth breather? ________________________________ Yes No

Have you ever seen an orthodontist? If yes, who and when? __________________ Yes No

Has anyone in your family received orthodontic treatment? __________________ Yes No

What is your attitude toward receiving orthodontic treatment? ______________________________

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous. It is my responsibility to inform the dental office of any changes in my (or my child's) medical status. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to myself or child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for my payment of all services rendered on myself or behalf of my child.

Signature of Patient or Parent: ______________________________ Date: ______________