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: ____________________

SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

____
Patient Name

____ ______________
Parent/Guardian Name *(if applicable)* Relation

____ ______________
Patient/Parent/Guardian Signature Date

CLEAR FORM

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NYBERG ORTHODONTICS

Lynnette Nyberg DMD, MSD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____

For Office Use Only

____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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I, ______________________________, hereby authorize Nyberg Orthodontics to disclose facial and/or dental photographs of the following patient as approved below:

Patient Name: ____ **Patient DOB** _____/_____/_____

Please check the appropriate answer to each of the following questions:

1. May the patient's picture be displayed on the ***reception computer screen*** for patient sign-in purposes?
   ☐ Yes ☐ No

2. May the patient's picture be displayed ***on the office website, Facebook account and/or within the office*** for the purpose of informing patients of the positive outcome we have achieved?
   ☐ Yes ☐ No

3. May the patient's picture be displayed ***on the office website, Facebook account and/or within the office*** if they are a contest prize winner?
   ☐ Yes ☐ No

4. May the patient's records including photographs be used for the purposes of professional consultations, research, education or publication in ***professional journals***?
   ☐ Yes ☐ No

Please Note:

- Financial Disclosure: I understand that the practice is not receiving compensation for use of the patient's photo.
- Refusal to Sign: I understand that refusal to sign part or all of this Authorization will in no way affect the patient's treatment.

Certification:

☐ I certify that I am the authorized representative for the patient. *My relationship to the patient is:*

____

☐ I certify that I am the patient.

Signature:___________________________________ ***Date:***______________

Witness:____________________________________ ***Date:*** ______________