NEW ROCHELLE ORTHODONTICS

Patient Information

Name _____ (Last) _____ (First) _____ (Middle) Sex Marital Status

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ (MM-DD-YYYY) E-mail _____ Social Security# _____ (999-99-9999)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) ext. _____

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

Who may we thank for referring you to our office _____

Spouse / Additional Contact Information

Name _____ (Last) _____ (First) _____ (Middle) Marital Status

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ (MM-DD-YYYY) E-mail _____ Relationship to Patient _____

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) ext. _____

Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Social Security # _____ (999-99-9999)

Policy Owner's Birthdate _____ (MM-DD-YYYY) Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Secondary Insurance

Policy Owner's Name _____ Policy Owner's Social Security # _____ (999-99-9999)

Policy Owner's Birthdate _____ (MM-DD-YYYY) Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Medical History

Are you under the care of a physician? ☐ Yes ☐ No If Yes, explain _____

Physician _____ Phone _____ Last Visit _____

Address _____

Are you pregnant ☐ Yes ☐ No If so how many weeks _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you tonsils or adenoids been removed? ☐ Yes ☐ No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☐ No if Yes, explain _____

Do your gums bleed? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Does/Have you ever had any of the following habits?

☐ Lip Sucking/Biting ☐ Nail biting ☐ Prolonged Bottle/Pacifier

☐ Clenching/Grinding Teeth ☐ Mouth Breather ☐ Tongue Thrusting ☐ Thumb/ Finger Sucking

Are you allergic to any of the following?

☐ Aspirin ☐ Erythromycin

☐ Codeine ☐ Penicillin

☐ Tetracycline ☐ Latex

☐ Any Metals/Plastics

Other Allergies/Sensitivites:

_____

List all drugs you are currently taking

List any serious medical condition(s) treated

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____ Date _____

Submit