



Specialist in Orthodontics for Children & Adults

Please take a few minutes to fill out this necessary information that will enable us to better serve you. We will be happy to assist you with any questions you may have.

PATIENT INFORMATION:

Today's date: _____

Patient's Name: _____
Last First Middle

Nickname: _____ SSN: _____

Birth date: _____ Age: _____ Male: _____ Female: _____

Home Address: _____

Home Phone #: (____) _____ Occupation _____

Email Address: _____

Whom may we thank for referring you to our office? _____

Why are you currently seeking treatment? What would you like orthodontic treatment to accomplish? _____

FAMILY INFORMATION:

Spouses Name: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Address (if different from above): _____

Marital Status: _____

Emergency Contact: _____

Name

Relation to patient

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relation to patient: _____

Billing Address: _____

Employer: _____ Phone #: _____

SSN: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

INSURANCE:

Primary Orthodontic Insurance:

Insurance Company's Name: _____ Ins. Co. Phone #: _____

Insurance Company's Address: _____

ID#: _____ Group #: _____ Ortho Coverage Y/N: _____

Policy Owner's Name: _____ Relation to patient: _____

Policy Owner's DOB: _____ Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance:

Insurance Company's Name: _____ Ins. Co. Phone #: _____

Insurance Company's Address: _____

ID#: _____ Group #: _____ Ortho Coverage Y/N: _____

Policy Owner's Name: _____ Relation to patient: _____

Policy Owner's DOB: _____ Policy Owner's Employer: _____

Employer's Address: _____

MEDICAL HISTORY:

Physician's Name: _____ Last Visit: _____ Phone #: _____

Address: _____

Current medical health: Excellent _____ Good _____ Fair _____ Poor _____

Height: _____ Weight: _____

Is patient currently under the care of a physician? If yes, please explain: _____

Is patient taking any medications? Y/N If so, list: _____

Has patient ever been hospitalized? If yes, please explain: _____

Is patient allergic to the following?

Local Anesthesia	Y/N	Latex	Y/N
Penicillin/Other Antibiotics	Y/N	Metals	Y/N
Sulfa Drugs	Y/N	Plastics	Y/N
Aspirin	Y/N	Iodine	Y/N

Other allergies: _____

Has patient ever had any of the following diseases or medical conditions?

Abnormal/ Prolonged bleeding	Y/N	Congenital Heart Defect	Y/N	Kidney Problems	Y/N
ADHD	Y/N	Diabetes	Y/N	Neurologic Disorders	Y/N
Anemia	Y/N	Drug/Alcohol Abuse	Y/N	Osteoporosis	Y/N
Angina/ Chest pain	Y/N	Epilepsy/Seizures	Y/N	Pyschiatric Disorders	Y/N
Artificial joints/valves	Y/N	Fever Blisters/Herpes	Y/N	Rheumatic/Scarlet Fever	Y/N
Arthritis	Y/N	Glaucoma	Y/N	Severe/Frequent Headaches	Y/N
Asthma	Y/N	Heart Disease	Y/N	Shortness of Breath	Y/N
Birth Defects	Y/N	Heart Murmur	Y/N	Sinus Problems	Y/N
Bone Disorders	Y/N	Hepatitis	Y/N	Surgeries	Y/N
Blood transfusions	Y/N	High/Low Blood Pressure	Y/N	Thyroid/Parathyroid Disorders	Y/N
Cancer/Chemotherapy/Radiation	Y/N	HIV+/AIDS	Y/N	Tuberculosis	Y/N

Other: _____

Please list any other serious past or current medical problems: _____

Female patients: Are you pregnant? Y/N Week #: _____

DENTAL HISTORY:

Dentist's Name: _____ Last Visit: _____ Phone #: _____

Address: _____

Current dental health: Excellent _____ Good _____ Fair _____ Poor _____

Periodontist's Name: _____ Last Visit: _____ Phone # _____

Oral Surgeon's Name: _____ Last Visit: _____ Phone # _____

Has patient ever had a serious/difficult problem associated with any previous dental work? Y/N _____

Has patient been informed of any missing/extra teeth? Y/N _____

Has patient ever been evaluated for orthodontic treatment? Y/N _____

Habits:

Clenching/Grinding Teeth Y/N Thumb/Finger sucking Y/N Tongue thrust Y/N

Mouth Breather Y/N Nail Biting Y/N Speech Problems Y/N

Has patient ever experienced:

Unfavorable reaction to local anesthesia Y/N

Pain/discomfort in the jaw joint? Y/N

Locked jaw? Y/N

Pain in the jaw joint Y/N

Clicking or popping in the jaw? Y/N

Frequent/severe headaches? Y/N

Ringing in the ears? Y/N

Has patient ever had an injury to the: face? _____ mouth? _____ teeth? _____ chin? _____

Would you like to see an improvement in the patient's facial appearance? Y/N How? _____

Has patient ever taken Fosamax, Actonel, Bonivia or any other bisphosphonate? _____

Does patient smoke or use tobacco in any form? Y/N _____

To the best of my knowledge, all the preceding answers are correct. I understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status. I hereby give permission to Dr. Ira Goldberg and his clinical team to take any x-rays, photographs and/or study models deemed necessary to enable complete diagnosis and treatment planning.

Patient

Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agencies.

If this office accepts insurance, I understand that I am responsible for payment of services rendered for which my insurance does not cover.

Signature Date

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.