WELCOME

TO THE ORTHODONTIST

Dr. Joseph Arvay Dr. Michael Goldkind

About You

Today's Date: _____
Name: _____
Preferred Name: _____ ☐ Male ☐ Female
Birthdate: ____/____/____ Age: _____
Home Address:
_____
_____
Home #: _____
Cell #: _____ Work #: _____
E-Mail: _____
Occupation: _____
Employer: _____
General Dentist: _____
Last Visit Date: _____
Whom may we thank for referring you? ☐ General Dentist
☐ Friend _____ ☐ Internet
☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Partnered ☐ Separated
Other family members seen by us: _____
_____

Spouse Information

His/Her Name: _____
Employer: _____
Cell #: _____

In the event of an emergency, is there someone who lives near you that we should contact?
His/Her Name: _____
Relation: _____
Phone #: _____

Primary Ortho Insurance

Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____
Insurance Co. Name: _____
Insurance Policy ID #: _____
Policy Owner's Employer: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Insurance Co. Group #: _____

Secondary Ortho Insurance

Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____
Insurance Co. Name: _____
Insurance Policy ID #: _____
Policy Owner's Employer: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Insurance Co. Group #: _____

I certify that I am covered by the above Insurance Co. and I assign directly to Flanders Pediatric Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

Medical History

Do you have a personal physician? Y N

Physician's Name: _____

Phone # _____ Date of last visit: _____

Please describe your current physical health:

Good Fair Poor

Are you currently under the care of a physician? **Y N**

Please Explain: _____

Are you taking any prescription/over-the-counter drugs? **Y N**

Please list each one: _____

_____

For Women: Are you using a prescribed method of birth control?

Y N

Are you pregnant? **Y N** Week #: _____

Are you nursing? **Y N**

Have you ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Anemia	Y	N	High/Low Blood Pressure
Y	N	Artificial Bones/Joints/Valves	Y	N	HIV+ / AIDS
Y	N	Asthma/Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Blood Transfusion	Y	N	Kidney Problems
Y	N	Cancer/chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic/ Scarlet Fever
Y	N	Emphysema	Y	N	Severe/Frequent Headaches
Y	N	Epilepsy/Seizures/Fainting	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers/Colitis
Y	N	Heart Surgery/Pacemaker	Y	N	Venereal Disease
Y	N	Hemophilia			

Please list any serious medical condition(s) that you have ever had? _____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Any Metals/Plastics	Y	N	Penicillin
Y	N	Codeine	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Other
Y	N	Erythromycin			

Please list any other drugs/materials that you are allergic to:

_____

_____

Dental History

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

_____

_____

Have you ever been evaluated or had orthodontic treatment before? **Y N**

Have you ever had a serious/difficult problem associated with any previous dental work? **Y N**

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? **Y N** Gums ever bleed? **Y N**

Have you ever had an injury to you: Mouth Teeth Chin

Do you have any speech problem? _____

Do you generally breathe through your mouth? **Y N**

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? **Y N**

Have you ever taken Fosamax, or any other bisphosphonate? **Y N**

Have you ever taken Phen-Fen? **Y N**

Do you smoke or use tobacco in any form? **Y N**

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

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

_____

____ Individual refused to sign Signature Date