Huntington ORTHODONTICS AND DENTAL SPECIALTIES

Date: ____/____/____

Patient Information

Patient's name: _____ ____ _____ Sex: ❒ M ❒ F
First MI Last

Address: _____ _____ _____
Street City Zip

Birth Date: ____/____/____ Age: _____

Home Phone: _____ Cell Phone (*): _____

Cell Phone Service (AT&T, Verizon, etc.): _____

(*) May we text message this, or another cell # for appointment reminders? ❒ Yes ❒ No

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

Please list other family members seen at this office and their relationship to this patient: _____

Responsible Party Information

Name: _____ ____ _____
First MI Last

Address (if different): _____ _____ _____
Street City Zip

Relationship to patient: _____ Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widowed

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email address (for billing statements, appointment reminders, etc.): _____

Spouse's Name: _____ ____ _____
First MI Last

Relationship to patient: _____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Patient lives with: ❒ Both Parents Together ❒ Both Parents Separately ❒ Mother ❒ Father
❒ Adult (N/A) ❒ Other: _____

Dental Insurance Information

Primary Insurance Company _____ Group/Plan/Local No. _____

Insurance Co. Address _____ Phone No. _____

Policy Owner's Name _____ Social Security #_____-_____-_____

Birth Date: ____/____/____

* Do you have dual coverage? ❒ Yes ❒ No If yes, complete below:

Secondary Insurance Company _____ Group/Plan No. _____

Insurance Co. Address _____ Phone No. _____

Policy Owner's Name _____ Social Security #_____-_____-_____

Birth Date: ____/____/____

Medical History

Physician: _____ Date of Last Visit: _____

Please check Yes or No (If Yes, please fill in details)

Yes	No	
❒	❒	Is the patient in good health? _____
❒	❒	Is the patient taking any medication? Please list: _____
❒	❒	Is the patient allergic to any medication? Please list: _____
❒	❒	Has the patient ever been involved in a serious accident? Explain: _____
❒	❒	Does the patient now or has he/she ever taken Bisphosphonates? (i.e. Fosamax, Zometa, Boniva, Aredia, Actonel, etc) If yes, which drug? _____

Female Patients only:

Yes	No	
❒	❒	Has menstruation begun? At what age? _____
❒	❒	Are you pregnant? If yes, what is the due date? _____

Does the patient have or has he/she had any of the following diseases or conditions? (check Yes or No)

Yes	No		Yes	No	
❒	❒	Abnormal bleeding/Hemophilia	❒	❒	HIV / Aids
❒	❒	Anemia	❒	❒	Joint Replacement or Implant
❒	❒	Arthritis	❒	❒	Kidney problems
❒	❒	Asthma	❒	❒	Latex or Nickel Allergy/Sensitivity
❒	❒	Bone Disorders	❒	❒	Nervous Disorders
❒	❒	Diabetes	❒	❒	Pneumonia
❒	❒	Fainting or Dizziness	❒	❒	Radiation/Chemotherapy
❒	❒	Epilepsy	❒	❒	Rheumatic Fever
❒	❒	Heart Defect, Murmur, or Disease	❒	❒	Tuberculosis
❒	❒	Hepatitis (If yes, circle A B C)	❒	❒	Tumor or Cancer
❒	❒	Herpes/Fever Blisters	❒	❒	Tonsils/Adenoids removed
❒	❒	High or Low Blood Pressure			

Are there any medical conditions, diseases or problems not discussed that you feel we should be aware of?_____
_____

Dental History

General Dentist: _____ Date of last visit: _____

What are the main concerns you would most like orthodontics to address? _____
Patient's attitude towards orthodontic treatment: ❒ Very Motivated ❒ Will Cooperate (if needed) ❒ Not Motivated

Yes	No	
❒	❒	Is the patient experiencing any dental problems/pain? _____
❒	❒	Have there been any injuries to: (select all that apply) ❒ Face ❒ Mouth ❒ Teeth
❒	❒	Has an orthodontist been consulted previously? Reason:_____
❒	❒	Are you aware that some appointments will be during school/work hours?

Does the patient have or has he/she had any of the following diseases or conditions? (check Yes or No)

Yes	No		Yes	No		Yes	No	
❒	❒	Tongue Thrust habit	❒	❒	Missing Permanent Teeth	❒	❒	Difficulty Chewing
❒	❒	Finger/Thumbsucking habit	❒	❒	Extra Permanent Teeth	❒	❒	Fear of Dental Work
❒	❒	Fingernail biting	❒	❒	Jaw Pain (TMJ/TMD)	❒	❒	Previous Orthodontics
❒	❒	Mouthbreather	❒	❒	Jaw Joint clicking/popping	❒	❒	Sore or Bleeding Gums
❒	❒	Clenching/Grinding	❒	❒	Permanent Tooth removal/extraction			

Personal Information (Child)

School:_____ Grade: _____
Hobbies & Interests: _____
Brothers/Sisters (ages): _____

I acknowledge that the above information is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the doctor of any changes that occur after this date. I hereby authorize the doctor and his/her team to take x-rays and perform a complete evaluation/examination.

Signature: _____ **Date:** _____
(Patient or Guardian)