NEW ROCHELLE ORTHODONTICS

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info@newrochelleortho.com

Patient Information

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

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

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

Home Phone _____ (999-999-9999) General Dentist _____ Last Visited _____

Who may we thank for referring you to our office _____

Parents Information

Father

Name _____ (Last) _____ (First) _____ (Middle) 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 _____

Relationship to Patient _____

Mother

Name _____ (Last) _____ (First) _____ (Middle) 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 _____

Relationship to Patient _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Employer _____

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

Insurance Co. Address _____ Insurance Phone No. _____

Do You have Dual Coverage

General Information

School _____

Hobbies

Brothers/Sisters (include ages)

Medical History

Medical Physician? _____ Phone _____ Last Visit _____

Is the child currently under the care of a physician? Yes No If Yes, explain _____

Has puberty begun? Yes No Has menstruation (period) begun? Yes No N/A

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

Has the patient ever been evaluated for orthodontic treatment? Yes No

Has the patient tonsils or adenoids been removed? Yes No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever had an injury to : (select all that apply) Teeth Mouth Chin

Does/Has the patient 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

Does the patient have speech problems? Yes No If Yes, explain _____

Is the child allergic to any of the following?	
Aspirin	Erythromycin
Codeine	Penicillin
Tetracycline	Latex
Any Metals/Plastics	

Other Allergies/Sensitivites:

_____

List all drugs the Patient is 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 confidence and it is my responsibility to inform this office of any changes in my child's 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 _____