



1990 Deer Park Ave.  
Deer Park, New York 11729  
Phone: (631) 586-7654  
www.ToothBracer.COM

**Patient Information**

Patient's Name: \_\_\_\_\_  Male  Female

\_\_\_\_\_ First Middle Last

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Street Town State Zip

If Patient is a minor, give parent's/guardian's name(s): \_\_\_\_\_

Names/Ages of brothers and sisters: \_\_\_\_\_

**Responsible Party Information**

Name: \_\_\_\_\_  Married  Divorced  Single  
\_\_\_\_\_ First Middle Last Marital Status

Custodial Parent:  Mother  Father  Both E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Street Town State Zip

How long at this address? \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Previous Address (if less then 3 yrs.) \_\_\_\_\_  
\_\_\_\_\_ Street Town State Zip

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
\_\_\_\_\_ First Middle Last

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

**Dental Insurance Information**

<u>Primary</u>	<u>Secondary</u>
Policy Holder: _____	Policy Holder: _____
SS# of Policy Holder: _____	SS# of Policy Holder: _____
Policy Holder's Date of Birth: ____/____/____	Policy Holder's Date of Birth: ____/____/____
Insurance Company: _____	Insurance Company: _____
Insurance Address: _____	Insurance Address: _____

Insurance Group/Policy#: \_\_\_\_\_ Insurance Group/Policy#: \_\_\_\_\_

- I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to North Shore Orthodontics of the insurance benefits otherwise payable to me.
- I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
- I certify that the above information is complete and true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient's Medical/Dental History**

Patient's Dentist: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Last Visit: \_\_\_\_\_

What is patient's/parent's primary concern: \_\_\_\_\_

Patient's Physician: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Last Visit: \_\_\_\_\_

Is patient presently being treated by a physician? Yes No Why?: \_\_\_\_\_

Has the patient's tonsils and adenoids been removed? Yes No Is child adopted? Yes No

Has the patient ever had an unusual reaction to any drug? Yes No Is child aware of adoption? Yes No

Does patient have a speech problem, if so are they receiving therapy? Yes No

Has the patient any of the following?

- Heart Murmur
- Rheumatic Fever
- Mitral Valve Prolapse
- Pre Medication Required
- Anemia
- Bleeding Problems
- Gum Problems
- Tuberculosis
- Diabetes
- Epilepsy
- Convulsions/Seizures
- Immune Deficiency
- Smoke Cigarettes/Cigars
- Asthma
- Breathing Problems
- Frequent Colds
- Sinus Problems
- Cold Sores
- ADD/ADHD
- Ulcers
- Thyroid/Hormonal Imbalance
- Lip Biting
- Nail Biting
- Tongue Thrusting
- Presently Suck Thumb/Finger
- Arthritis
- Problems Opening/Closing
- Chewing Problems
- Jaw Popping
- Grinding/Clenching
- Concussion
- Injury to Teeth/Jaws
- Severe Headaches
- Facial Pain
- Any TMJ History
- Nervous Disorder
- Hearing Problem
- Latex Allergy
- Metal Allergy
- Seasonal Allergy
- Other Allergy: List: \_\_\_\_\_
- Major Surgery

Has Patient ever had orthodontic treatment or worn a retainer? Yes No

Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: \_\_\_\_\_

If Female: Menstruating? Yes No Date of First Period: \_\_\_/\_\_\_/\_\_\_

If Male: Voice Change? Yes No Date Started: \_\_\_/\_\_\_/\_\_\_ Shaving? Yes No Date Started: \_\_\_/\_\_\_/\_\_\_

Names of Daily Medications? \_\_\_\_\_

Is there any other information about the patient's health we should know? \_\_\_\_\_

**Whom may we thank for the referring you to our office?**

Please circle all that apply:

My Dentist    Staff Member at My Dentist Office    Selected Doctor from Insurance Provider List

North Shore Orthodontics Website    Invisalign® Website    Yellow Page Ad    Newspaper Ad in: \_\_\_\_\_

My Friend/Relative Referred Me (list name(s)): \_\_\_\_\_

Other (please specify): \_\_\_\_\_

Signature (Parent's if minor): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Review by Doctor: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_