Adult Patient Information

Please select: □Dr. □Mr. □Mrs. □Ms.

Name (Last, First):_____

Date of Birth: _____ Gender: □Male □Female □Non-Binary

Telephone Number: _____ Email: _____

Street Address: _____

Marital Status: □Single □Married □Widowed □Separated □Divorced

General Dentist (Required):_____

Have you had an orthodontic evaluation/treatment (if so, what time period?) _____

What concerns you most about your teeth? _____

Any family members currently undergoing orthodontic treatment? □Yes □No

Whom May We Thank For Referring You? □Dentist _____□Internet _____

□ Primary Doctor_____ □Friend _____ □Other _____

Who make financial payments for services rendered at Central Park West Orthodontics: □Myself □Other

If you have selected other please completed the following:

Please select: □Dr. □Mr. □Mrs. □Ms.

Name (Last, First):_____

Date of Birth: _____ Gender: □Male □Female □Non-Binary

Street Address: (Same as above □) _____

Telephone Number: _____ Email: _____

Marital Status: □Single □Married □Widowed □Separated □Divorced

Relationship to patient: _____

What is the primary contact for your treatment? □ Call □ Email □ Text

Emergency Contact Information

In case of an emergency, please provide the name of the nearest relative <u>not living with you</u>:

Emergency Contact's Name (Last, First):_____

Emergency Contact's relationship to patient: _____

Emergency Contact's Phone Number:_____

Dental Insurance Information (Primary)

Policy Holder's Full Name: _____Policy Holder's Date of Birth: __ __/ __ __/ __ __ __ __

Employer's Name: _____ Policy Holder's SSN: ___ ___ ___ - __ __ - __ __ ___ ___

Insurance Company: _____Policy Holder ID Number: _____

Group Number: _____ Insurance Company Address: _____

Medical History

Physician's full name: _____

Physician's Phone Number: _____

Describe what is your current health status?_____ Date of last Visit: _____

Select any of the following medical/health concerns? (Check all that apply past/present)

- ☐Abnormal Bleeding
- ☐ Anemia
- ☐Artificial Bones
- ☐Joints Valve
- ☐Asthma
- ☐Arthritis
- ☐Attention Deficit Disorder
- ☐Transfusion Blood
- ☐Cancer
- ☐Chemotherapy
- ☐Congenital Heart Defect
- ☐Diabetes
- ☐Difficult Breathing
- ☐Drug Abuse
- ☐Emphysema
- ☐Epilepsy
- ☐Seizures
- ☐Fainting
- ☐Fever Blisters
- ☐ Herpes
- ☐ Handicap Disabilities
- ☐ Heart Attack / Stroke
- ☐Heart Murmur
- ☐Heart Surgery
- ☐Pacemaker
- ☐Hemophilia
- ☐Hepatitis
- ☐Low Blood Pressure
- ☐High Blood Pressure
- ☐HIV+
- ☐AIDS
- ☐Hospitalized for Any Reason
- ☐Kidney Problems
- ☐Menstruation
- ☐Mitral Valve Prolapse
- ☐Psychiatric Condition
- ☐Radiation Treatment
- ☐Rheumatic/ Scarlet Fever
- ☐Severe / Frequent Headaches
- ☐Sickle Cell Disease/ Traits
- ☐Sinus Problems
- ☐Sleep Apnea
- ☐TMD
- ☐TMJ
- ☐Tuberculosis
- ☐Ulcers/ Colitis
- ☐No Medical Conditions

Are you allergic to any of the following?

- ☐Aspirin
- ☐Any Metals/Plastics
- ☐Codeine
- ☐Dental Anesthetics
- ☐Erythromycin
- ☐Latex
- ☐Penicillin
- ☐Amoxicillin
- ☐Tetracycline
- ☐Other (Please indicate in the entry below)

Other Allergies: _____

Please list any medication that you are taking: _____

Any of the following dental concerns? (Check all that apply)

- ☐Have you previously suck your thumb or fingers?
- ☐Are you currently sucking thumb or fingers?
- ☐Do you breathe predominantly through the mouth?
- ☐Do you have any speech impediment?
- ☐Do you clench or grind teeth (at night)?
- ☐Have you had any head or face injuries?
- ☐Have any teeth been chipped due to accidents?
- ☐Have you been informed of missing permanent teeth?
- ☐Have you been informed of any extra teeth?
- ☐Were any teeth removed by extraction?
- ☐Any difficulty in chewing your food?
- ☐ Any difficulty in swallowing your food?
- ☐Do you bite or suck your lips?
- ☐Do you have pain or clicking upon closing the mouth?
- ☐Do you have Temporomandibular Joint Disorders?
- ☐Other _____ ☐None

☐Baby or ☐Permanent

Do you brush daily? How many times per a day? _____

Do you floss daily? How many times per a day? _____

Has the child had tonsils / adenoids removed? If so when? _____

Discuss any other medical concerns your child may have: _____

Authorization for Release of Patient Information

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontics care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any future release by the individual receiving this information.
Please Initial: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status and updates to their account. I authorize the dental staff to perform the necessary dental service my child may need. I understand that I am responsible for payment of services rendered at this office. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

Please sign and date:_____