WESTCHESTER
family orthodontics

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Welcome to our office.
Please allow us to get to know you better by
filling out both sides of this questionnaire

Date ____________

PATIENT INFORMATION:

Name ____________ (Last) ____________ (First) ____________ (Preferred Name) ____________ (Middle) ____________ (Sex)

Address ____________ (Street) ____________ (City) ____________ (State) ____________ (Zip) Marital Status ____________

Birthdate ____________ E-mail ____________ Social Security# ____________ Home Phone ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

General Dentist ____________ Last Visited ____________

Who may we thank for referring you to our office? ____________

SPOUSE/ADDITIONAL CONTACT INFORMATION:

Name ____________ (Last) ____________ (First) ____________ (Middle) ____________ (Marital Status)

Address ____________ (Street) ____________ (City) ____________ (State) ____________ (Zip)

Birthdate ____________ E-mail ____________ Social Security# ____________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Relationship to Patient ____________

INSURANCE INFORMATION:

Policy Owner's Name ____________ Policy Owner's Social Security# ____________

Policy Owner's Birthdate ____________ Relationship to Patient ____________

Policy Owner's Employer ____________ Employer's Address ____________

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

Insurance Co. Address ____________ Insurance Phone No. ____________

SECONDARY INSURANCE:

Policy Owner's Name ____________ Policy Owner's Social Security# ____________

Policy Owner's Birthdate ____________ Relationship to Patient ____________

Policy Owner's Employer ____________ Employer's Address ____________

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

Insurance Co. Address ____________ Insurance Phone No. ____________

MEDICAL HISTORY:

Are you under the care of a physician? ☐ Yes ☐ No If yes, explain ____________

Physician ____________ Phone ____________ Last Visit ____________

Address ____________

Are you pregnant? ☐ Yes ☐ No If so, how many weeks ____________

Are you allergic to any of the following? Yes No If yes, please check all that apply

☐ Aspirin ☐ Codeine ☐ Tetracycline ☐ Any Metals/Plastics ☐ Other Allergies/Sensitivities

☐ Erythromycin ☐ Penicillin ☐ Latex

Please list all medications the patient is currently taking

Please list any serious medical condition(s) treated in past or present

DENTAL HISTORY:

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

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have your tonsils or adenoids been removed? ☐ Yes ☐ No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☐ No If Yes, explain

Do your gums bleed? ☐ Yes ☐ No Do you smoke/use tobacco ? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Do/Have you ever had any of the following habits? ☐ Yes ☐ No If yes, please check all that apply

☐ Lip Sucking/Biting ☐ Nail Biting ☐ Prolonged Bottle/Pacifier ☐ Clenching/Grinding Teeth

☐ Mouth Breather ☐ Tongue Thrusting ☐ Thumb/Finger Sucking

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 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.

Signature of patient ____________ Date ____________