WELCOME TO BRODSKY ORTHODONTICS

PLEASE PRINT & COMPLETE BOTH THE FRONT & BACK

PATIENT'S NAME: ______________________ BIRTHDAY: __________ AGE IN YRS: _____ MOS: ______

TODAY'S DATE: ____________ SEX: ______ HEIGHT: _______ E-MAIL: ______________________

ADDRESS: ______________________ CITY: ____________ STATE: _____ ZIP: __________

YOUR INFORMATION

SOCIAL SECURITY # ____________________ DOB________

➤ *Please check which number is the best to reach you during the day*

☐ HOME # ______________

☐ WORK # ______________

☐ CELL # ______________

EMPLOYED BY: ______________________

BUSINESS ADDRESS: ______________________

CITY: ______________ STATE: ______ ZIP: _______

SPOUSE'S NAME ______________________

SOCIAL SECURITY # ____________________ DOB________

➤ *Please check which number is the best to reach you during the day*

☐ HOME # ______________

☐ WORK # ______________

☐ CELL # ______________

EMPLOYED BY: ______________________

BUSINESS ADDRESS: ______________________

CITY: ______________ STATE: ______ ZIP: _______

HOW WERE YOU REFERRED?

☐ DENTIST ☐ FAMILY ☐ FRIENDS

☐ DRIVE-BY ☐ WEBSITE ☐ INVISALIGN

☐ OTHER ______________________

↓ REFERRAL'S FULL NAME

____

PLEASE *CIRCLE* EITHER **YES** OR **NO** TO THE FOLLOWING:

YES NO – HAS THIS PATIENT EVER BEEN SEEN FOR ANY OTHER ORTHODONTIC CONSULTATION?

IF YES, WHO WAS THE ORTHODONTIST? ______________________ DATE: ________

YES NO – HAS THIS PATIENT EVER HAD PREVIOUS ORTHODONTIC TREATMENT?

WHO WAS THE ORTHODONTIST? ______________________ CITY: __________

YES NO - ***HAS ANYONE IN YOUR FAMILY HAD ORTHODONTIC TREAMENT IN OUR OFFICE?***

☐ BROTHER/SISTER ☐ MOM/DAD ☐ AUNT/UNCLE ☐ COUSIN ☐ OTHER __________

FAMILY MEMBER'S FIRST & LAST NAME:______________________

PRIMARY INSURED INFORMATION

Name of Insured: ___How does the insured's name appear on the insurance card?___

Insured's DOB: ___MM/DD/YY___ Insured's SSN or ID: ______________

Relationship to Patient: ___mother, stepfather, grandmother, etc.___

Address of Insured: ___write same if same as patient's address___

City: ______________ State: ______ Zip: ________

Employed by: ______________________

Work Address: ___write same if you have written on this page already___

City: ______________ State: ______ Zip: ________

Dental Ins Co. Name: ___Complete name Ex: Cigna include here if this plan is HMO/PPO___

Ins Address: ______________________

City: ______________ State: ______ Zip: ________

SECONDARY INSURED INFORMATION

Name of Insured: ___How does the insured's name appear on the insurance card?___

Insured's DOB: ___MM/DD/YY___ Insured's SSN or ID: ______________

Relationship to Patient: ___mother, stepfather, grandmother, etc.___

Address of Insured: ___write same if same as patient's address___

City: ______________ State: ______ Zip: ________

Employed by: ______________________

Work Address: ___write same if you have written on this page already___

City: ______________ State: ______ Zip: ________

Dental Ins Co. Name: ___Complete name Ex: Cigna include here if this plan is HMO/PPO___

Ins Address: ______________________

City: ______________ State: ______ Zip: ________

Ins Group # ______________ Ins Phone: ______________

FOR OFFICE USE ONLY

DIAG RECORDS: $ __________

TREATMENT FEE: $ __________

INSURANCE: $ __________

PERSONAL: $ __________

DOWN PMT: $ __________

MONTHLY PMTS: $ __________

Consult: Dr B C

TMJ ______________

U - TYPE: Mini Ice

L - TYPE: Mini Ice

Treatment: Full

Phase 1

Appliance(s): Limited

Surgical

Invisalign

Extraction(s): __________

PATIENT'S NAME: ____

PATIENT'S DENTAL HISTORY

LAST DENTAL APPT. ______________

DENTIST NAME: FIRST____________________ LAST ________________________ Phone: ______________________

DENTIST'S ADDRESS: ____CITY: ______________________ ZIP: _____________

PLEASE CHECK REASONS FOR SEEKING AN ORTHODONTIC CONSULTATION:

- ☐ FRONT TEETH PROTRUDING
- ☐ CROWDED TEETH
- ☐ SPACES BETWEEN TEETH
- ☐ OVERBITE/UNDERBITE
- ☐ JAW/JOINT PAIN
- ☐ OTHER______________________________

*PLEASE CIRCLE EITHER **YES** OR **NO** TO THE FOLLOWING:*

YES NO – Did your dentist encourage you to seek this consultation?
YES NO – Do you have any missing or extra teeth?
YES NO – Have you ever had any difficulty with past dental treatments?
YES NO – Have you ever been told you have gum problems?
YES NO – Do you have trouble opening your mouth wide?
YES NO – Do your jaws ever click or pop?
YES NO – Do you have pain in front of your ears?
YES NO – Do you have pre-existing TMJ problems?
YES NO – Have you ever had an injury to your face, neck, jaws, or teeth? Explain: ____

CHECK HABITS:

- ☐ Nail Biting
- ☐ Thumb Sucking
- ☐ Night Grinding
- ☐ Finger Sucking
- ☐ Mouth breathing
- ☐ Lip Biting
- ☐ Other _________________________________

What Are You Interested In: ☐ Invisalign ☐ Mini (metal) Braces ☐ Clear (ceramic) Braces ☐ Retainers

PLEASE INDICATE YOUR CONCERNS ABOUT THE FOLLOWING:

YES NO – FEAR OF PAIN
YES NO – FEAR OF DENTISTS
YES NO – WANTS TREATMENT
YES NO – TRUST IN DENTISTS
YES NO – FINANCIAL CONCERNS
YES NO – OUTSIDE CONFLICTS

PATIENT'S MEDICAL HISTORY

It is required by law that we have a complete medical history for all our patients. Please answer the following question as accurately as possible.

PLEASE CIRCLE EITHER YES OR NO TO THE FOLLOWING MEDICAL INFORMATION:

YES NO – Have you been a patient in a hospital during the past 2 years?
YES NO – Are you currently being treated by your physician?
YES NO – Are you currently taking Fosamax or any Bisphosphonates?
YES NO – Are you taken any kind of medicine or drugs? **Please list MEDS →**
YES NO – Do you wear contact lenses?
YES NO – Do you smoke? How much? ____________________________
YES NO – Do you suffer from frequent or severe headaches, neck, or back pain?

PLEASE LIST ANY MEDICATION(S) THE PATIENT IS PRESENTLY ON OR HAS TAKEN IN THE PAST YEAR:

________________ ________________
________________ ________________
________________ ________________

Are you allergic to any of the following?

YES NO – Latex
YES NO – Any Metals/Plastic
YES NO – Erythromycin
YES NO – Codeine
YES NO – Dental Anesthetics
YES NO – Tetracycline
YES NO – Penicillin
Please List any other allergies ________________________

FEMALES ONLY:

YES NO - Is there a possibility you may be pregnant?
YES NO - Are you pregnant?
How many months? _______
YES NO - Are you nursing?

Physician's Name: ____

Address: ____ City: __________________ Phone: __________________

Have you ever had any of the following diseases or medical conditions? *You must circle either Y or N*

Y N Abnormal Bleeding	Y N Diabetes	Y N Hemophilia	Y N Radiation Treatment
Y N Anemia	Y N Dizziness/Fainting	Y N Hepatitis	Y N Rheumatic/Scarlet Fever
Y N Artificial Heart Valve	Y N Drug/Alcohol Abuse	Y N High/Low Blood Pressure	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Emphysema	Y N Hives/Skin Rash	Y N Steroid Use
Y N Asthma	Y N Epilepsy/Seizures	Y N Kidney/Liver Disease	Y N Thyroid Problems
Y N AIDS/HIV+	Y N Glaucoma	Y N Mitral Valve Prolapse	Y N Tuberculosis
Y N Bronchitis	Y N Heart Attack/Stroke/TIA	Y N Persistent Cough	Y N Ulcers/Colitis
Y N Cancer/Chemotherapy	Y N Heart Murmur	Y N Psychiatric Treatment	Y N Venereal Disease
Y N Congenital Heart Lesions	Y N Heart Pacemaker	Other ________________________	

To the best of my ability, all the information that I have provided on this form is accurate and current. In addition, I have given permission for Brodsky Orthodontics to use my email address for correspondence by including it on this form.

Reviewed by Dr. Brodsky
Date_________
Signature ____________

X SIGNATURE OF PATIENT ____Date:______________