

BRACE FOR CHILDREN & ADULTS

PRACTICE LIMITED TO ORTHODONTICS

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WWW.BRACEYOURSELFDENTAL.COM

Welcome

~To Our Orthodontic Practice~

The benefits of a happy, healthy Smile are immeasurable. A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

<p style="text-align: center;">Patient's Info</p> <p>Today's Date _____</p> <p>Name _____ <small>Last First</small></p> <p>I prefer to be called _____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Birth Date ____/____/____ SS# _____</p> <p>Home Address _____</p> <p>City _____ State _____ Zip _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated</p> <p>HTM(____) _____ Cell(____) _____</p> <p>WK(____) _____ EXT _____</p> <p>Employer Address _____</p> <p>How long there? _____ Occupation _____</p> <p>Best place to reach you. _____</p> <p>Who may we thank for referring you? _____</p> <p>Other family member seen by us. _____</p> <p>General Dentist _____</p> <p>Last Visit _____</p> <p style="text-align: center;">Spouse Information</p> <p>His/Her Name _____</p> <p>WK (____) _____ EXT _____</p> <p>Cell (____) _____</p> <p>Billing Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Relationship _____ SS# _____</p> <p>Employer _____</p>	<p style="text-align: center;">Insurance Info (Private)</p> <p>Orthodontic Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know</p> <p>Insurance Co. Name _____</p> <p>Insurance Co. Address _____</p> <p>Insurance Co. Phone (____) _____</p> <p>Group # (Plan, Local or Policy #) _____</p> <p>Insured Name _____</p> <p>Relationship to Patient _____</p> <p>Insured's Birth Date _____</p> <p>Insured's ID# or SS# _____</p> <p style="text-align: center;">Secondary Orthodontic Insurance</p> <p>Orthodontic Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know</p> <p>Insurance Co. Name _____</p> <p>Insurance Co. Address _____</p> <p>Insurance Co. Phone (____) _____</p> <p>Group # (Plan, Local or Policy #) _____</p> <p>Insured Name _____</p> <p>Relationship to Patient _____</p> <p>Insured's Birth Date _____</p> <p>Insured's ID# or SS# _____</p> <p style="text-align: center;">In The Event of an Emergency, is There Someone Who Lives Near You That We Should Contact?</p> <p>His/Her Name _____</p> <p>Relationship _____</p> <p>WK (____) _____ HM (____) _____</p> <p style="text-align: center;">Medical History</p> <p>Do you have a personal physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Physician's Name _____</p> <p>Phone (____) _____ Date of Last Visit _____</p> <p style="text-align: right;"><i>Continue On Back</i></p>
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<p style="text-align: center;"><i>Medical History</i></p> <p>Your current physical health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Are you currently under the care of a Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please Explain _____</p> <p>Are you taking any prescription and/or over-the-counter drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list each one _____</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Week#) _____</p> <p style="text-align: center;">Have You Ever Had Any of The Following Diseases or Medical Problems?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">YN Anemia/Radiation Treatment</td> <td style="width: 50%;">YN Heart Surgery/Pacemaker</td> </tr> <tr> <td>YN Artificial Bones/Joints</td> <td>YN Hemophilia/Abnormal</td> </tr> <tr> <td>YN Artificial Valves</td> <td>YN Hepatitis</td> </tr> <tr> <td>YN Asthma/Arthritis</td> <td>YN High/Low Blood Pressure</td> </tr> <tr> <td>YN Blood Transfusion</td> <td>YN HIV/Aids</td> </tr> <tr> <td>YN Cancer/Chemotherapy</td> <td>YN Hospitalized</td> </tr> <tr> <td>YN Congenital Heart Defect</td> <td>YN Kidney Problem</td> </tr> <tr> <td>YN Diabetes/Tuberculosis</td> <td>YN Mitral Valve Prolapsed</td> </tr> <tr> <td>YN Difficulty Breathing</td> <td>YN Psychiatric Problems</td> </tr> <tr> <td>YN Drug/Abuse</td> <td>YN Rheumatic/Scarlet Fever</td> </tr> <tr> <td>YN Emphysema</td> <td>YN Severe/Frequent Headaches</td> </tr> <tr> <td>YN Epilepsy/Seizures/Fainting</td> <td>YN Shingles</td> </tr> <tr> <td>YN Fever Blisters/Herpes</td> <td>YN Sinus Problems</td> </tr> <tr> <td>YN Heart Attack/Stroke</td> <td>YN Ulcers/Colitis</td> </tr> <tr> <td>YN Heart Murmur</td> <td>YN Venereal Disease</td> </tr> </table> <p>Please list any serious medical conditions that you have ever had: _____</p> <p style="text-align: center;">Are You Allergic to any of the following?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">YN Aspirin</td> <td style="width: 33%;">YN Anesthetics</td> <td style="width: 33%;">YN Penicillin</td> </tr> <tr> <td>YN Metal/Plastic</td> <td>YN Erythromycin</td> <td>YN Tetracycline</td> </tr> <tr> <td>YN Codeine</td> <td>YN Latex</td> <td>YN Other</td> </tr> </table> <p>Please list any other drugs that you are allergic to: _____</p>	YN Anemia/Radiation Treatment	YN Heart Surgery/Pacemaker	YN Artificial Bones/Joints	YN Hemophilia/Abnormal	YN Artificial Valves	YN Hepatitis	YN Asthma/Arthritis	YN High/Low Blood Pressure	YN Blood Transfusion	YN HIV/Aids	YN Cancer/Chemotherapy	YN Hospitalized	YN Congenital Heart Defect	YN Kidney Problem	YN Diabetes/Tuberculosis	YN Mitral Valve Prolapsed	YN Difficulty Breathing	YN Psychiatric Problems	YN Drug/Abuse	YN Rheumatic/Scarlet Fever	YN Emphysema	YN Severe/Frequent Headaches	YN Epilepsy/Seizures/Fainting	YN Shingles	YN Fever Blisters/Herpes	YN Sinus Problems	YN Heart Attack/Stroke	YN Ulcers/Colitis	YN Heart Murmur	YN Venereal Disease	YN Aspirin	YN Anesthetics	YN Penicillin	YN Metal/Plastic	YN Erythromycin	YN Tetracycline	YN Codeine	YN Latex	YN Other	<p style="text-align: center;"><i>What are The Main Concerns that You would Like Orthodontics To Address?</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="text-align: center;"><i>Dental History</i></p> <p>Have you ever had or been evaluated for orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, by who? _____</p> <p>Have you ever had a serious/difficult problem associated with any previous dental work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?</p> <p>Your current dental health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your gums ever bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had an injury to your: <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth <input type="checkbox"/> Chin</p> <p>Do you generally breathe through your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>When awake? <input type="checkbox"/> Yes <input type="checkbox"/> No When asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any missing or extra permanent teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Thank You for Filling out This Form Completely.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my information consent.

Signature

Date