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: _____

PARENTS ARE: ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED PATIENT LIVES WITH? _____

MOTHER'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: _____

FATHER'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: _____

PATIENT'S BROTHERS? Name _____ Age _____

Name _____ Age _____

PATIENT'S SISERS? Name _____ Age _____

Name _____ Age _____

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: _____

Ins Group # _____ Ins Phone: _____

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: _____

DIAG RECORDS: $ _____

TREATMENT FEE: $ _____

INSURANCE: $ _____

PERSONAL: $ _____

DOWN PMT: $ _____

MONTHLY PMTS: $ _____

FOR OFFICE USE ONLY

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 ☐ Lip Biting ☐ Pencil Biting
- ☐ Thumb ☐ Finger Sucking
- ☐ Night Grinding
- ☐ Mouth breathing
- ☐ Other _____

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

PLEASE INDICATE **PATIENT'S** CONCERNS ABOUT THE FOLLOWING:

YES NO – FEAR OF PAIN
YES NO – FEAR OF DENTISTS
YES NO – WANTS TREATMENT

PLEASE INDICATE **RESPONSIBLE PARTY'S** CONCERNS ABOUT THE FOLLOWING:

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 – Codeine
YES NO – Penicillin
YES NO – Any Metals/Plastic
YES NO – Dental Anesthetics
YES NO – Erythromycin
YES NO – Tetracycline

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

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 (Parent or Guardian, if minor) _____ Date:_____