South Bay Orthodontics

Margaret Zadnik-O'Connell, DDS | Members American Association of Orthodontists

439 Main Street • Islip, New York 11751
Tel: (631) 581-1150 • Fax: (631) 581-1152
www.LIOrthodontics.com

412 Jericho Turnpike • New Hyde Park, NY 11040
Tel: (516) 354-3724 • Fax: (516) 327-0528
www.LIOrthodontics.com

About You

Today's Date: _____

Name: _____

I prefer to be called: _____ ❒ Male ❒ Female

Birthdate: _____ Age: _____ SS# _____

Home Address: _____
Apt/Condo#

_____ _____ _____
City State Zip

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Hm#: _____ Cell#: _____

Wk#: _____

Email Address: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

GENERAL DENTIST _____

Address: _____

Town: _____ Phone: _____

Last Visit Date: _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk#: _____ Ext: _____

SS#: _____

Birthdate: _____

Orthodontic Insurance

Primary

Orthodontic Coverage? ❒ Yes ❒ No Dental Coverage? ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Insured's Birthday: _____

Insured's SS# _____

Insured Employer: _____

Secondary

Orthodontic Coverage? ❒ Yes ❒ No Dental Coverage? ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____

Insured's SS# _____

Insured Employer: _____

Continued on next page

Medical History

Do you have a personal physician? ❒ Yes ❒ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ❒ Good ❒ Fair ❒ Poor

Are you currently under the care of a physician? ❒ Yes ❒ No

Please explain: _____

Do you smoke or use tobacco in any form? ❒ Yes ❒ No

Have you had any metal rods, pins, or implants? ❒ Yes ❒ No

Are you taking any prescription or over-the-counter drugs? ❒ Yes ❒ No

Please list each one: _____

For Women: Are you taking birth control pills? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No Week #: _____

Are you nursing? ❒ Yes ❒ No

Have you ever had any of the following diseases or medical problems:

❒ Y ❒ No	Abnormal Bleeding	❒ Y ❒ No	Hepatitis
❒ Y ❒ No	AIDS	❒ Y ❒ No	Herpes / Fever Blisters
❒ Y ❒ No	Alcohol / Drug Abuse	❒ Y ❒ No	High Blood Pressure
❒ Y ❒ No	Anemia	❒ Y ❒ No	HIV
❒ Y ❒ No	Arthritis	❒ Y ❒ No	Hospitalized for any Reason
❒ Y ❒ No	Artificial Bones/Joints/Valves	❒ Y ❒ No	Kidney Problems
❒ Y ❒ No	Asthma	❒ Y ❒ No	Liver Disease
❒ Y ❒ No	Blood Transfusion	❒ Y ❒ No	Low Blood Pressure
❒ Y ❒ No	Cancer/Chemotherapy	❒ Y ❒ No	Mitral Valve Prelapse
❒ Y ❒ No	Colitis	❒ Y ❒ No	Pacemaker
❒ Y ❒ No	Congenital Heart Defect	❒ Y ❒ No	Psychiatric Problems
❒ Y ❒ No	Diabetes	❒ Y ❒ No	Radiation Treatment
❒ Y ❒ No	Difficulty Breathing	❒ Y ❒ No	Rheumatic / Scarlet Fever
❒ Y ❒ No	Emphysema	❒ Y ❒ No	Seizures
❒ Y ❒ No	Epilepsy	❒ Y ❒ No	Shingles
❒ Y ❒ No	Fainting Spells	❒ Y ❒ No	Sickle Cell Disease / Traits
❒ Y ❒ No	Frequent Headaches	❒ Y ❒ No	Sinus Problems
❒ Y ❒ No	Glaucoma	❒ Y ❒ No	Stroke
❒ Y ❒ No	Hay Fever	❒ Y ❒ No	Thyroid Problems
❒ Y ❒ No	Heart Attack / Surgery	❒ Y ❒ No	Tuberculosis (TB)
❒ Y ❒ No	Heart Murmur	❒ Y ❒ No	Ulcers
❒ Y ❒ No	Hemophilia	❒ Y ❒ No	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Please list all drugs/materials that you are allergic to:

_____

_____

Do we have your permission to display your child's before and after pictures on our bulletin board?
❒ Yes ❒ No

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY

I orally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments:

_____

_____

_____

Initials: _____ Date: _____

Dental History

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ❒ Yes ❒ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Do you still have your wisdom teeth? ❒ Yes ❒ No

Have you ever had an injury to your: ❒ Mouth ❒ Teeth ❒ Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth? ❒ Yes ❒ No
If yes, please indicate: ❒ While Awake? ❒ While Asleep?

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

Are you happy with the way your smile looks? ❒ Yes ❒ No

If not, what would you change? _____

Authorization

I certify that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that 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 my child may need during diagnosis and treatment, with my informed consent.

Signature: _____ Date: _____

HIPPAA Acknowledgement

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews. I understand that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my request restriction, they must follow the restriction. I also understand that I may revoke this consent at any time bymaking a request in writing, except for information already used or disclosed.

Signature: _____
Patient, parent or legal guardian

Date: _____

If signed by a patient representative, state relationship to patient:

_____