

**Child Patient Information ( 18 and younger )**

PLEASE PRINT

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
(Not needed if child is under 16)

Patient's Full Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Patient's Cell Phone \_\_\_\_\_ Patient's E-Mail \_\_\_\_\_

Names of Relatives Treated Here \_\_\_\_\_

Personal Dentist Name \_\_\_\_\_ Address \_\_\_\_\_ Tel.# \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_ Address & Phone \_\_\_\_\_

How would you like to receive appointment reminders? (check one) Phone  US mail  email  text message   
(For text messages, please provide cell# to which reminder should be sent: \_\_\_\_\_ and provider: \_\_\_\_\_ (ex. Verizon)

<p><b>Mother's Information</b> (circle one): Mrs, Miss, Ms, Dr, Rev, Prof, Rabbi</p> <p>Name _____</p> <p>Address _____</p> <p>Email _____</p> <p>SS# _____ Home Phone _____</p> <p>DOB _____ Work Phone _____</p> <p>Employer _____ Cell Phone _____</p>	<p><b>Father's Information</b> (circle one): Mr, Dr, Rev, Prof, Rabbi</p> <p>Name _____</p> <p>Address _____</p> <p>Email _____</p> <p>SS# _____ Home Phone _____</p> <p>DOB _____ Work Phone _____</p> <p>Employer _____ Cell Phone _____</p>
<p><b>Step Parent/ Other Guardian</b> SS# _____</p> <p>Name _____ Relation _____</p> <p>Home phone _____ Work Phone _____</p>	<p><b>Step Parent/ Other Guardian</b> SS# _____</p> <p>Name _____ Relation _____</p> <p>Home phone _____ Work Phone _____</p>

**Insurance Information**

We will be happy to assist you in filing your insurance claim. Please bring us a dental claim form for your insurance company with the patient information filled out and signed. However, all payments are the responsibility of the patient, and an account will not be put on hold awaiting insurance benefits.

**(WE DO NOT ACCEPT NO FAULT INSURANCE.)**

**Please check here if you DO have Orthodontic insurance:**

**FINANCING OPTION:** Our practice offers interest-free financing to assist our patients for orthodontic care. A credit check may be done to confirm your eligibility for financing if you elect to choose this option.

*I authorize Southern Tier Credit Center to obtain my consumer credit report from any or all of the three credit bureaus – Equifax, Experian or Trans Union.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**RECORD RELEASE AUTHORIZATION:**

I consent to examination and treatment of \_\_\_\_\_ by the orthodontists and staff of ORTHODONTIC GROUP OF THE FINGER LAKES. I authorize ORTHODONTIC GROUP OF THE FINGER LAKES to release any and all of the named patient's dental records, including but not limited to: records of office visits and treatment rendered, x-rays, x-ray reports and photographs. Such records may be released to another dentist or orthodontist, or any other health care professional, for the purposes of discussing my condition, consulting on my case, or reviewing my dental records. These records may also be released to any governmental agencies, insurance companies, employees of insurance companies, any managed care organizations which contract with my insurer for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to the named patient, or performing quality assurance reviews as required by law. This authorization shall remain in effect for fifteen years from the below said date.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**OFFICE USE ONLY:**

Model # \_\_\_\_\_ Office \_\_\_\_\_ Patient # \_\_\_\_\_ Information Update \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Initialed \_\_\_\_\_

Patient Name \_\_\_\_\_ Record No. \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. \_\_\_\_\_

1. When was your last physical exam? \_\_\_\_\_
2. Have there been any changes in your general health with the past year? \_\_\_\_\_
3. Is a physician for any reason treating you at present? \_\_\_\_\_
4. What medicine(s) are you taking now? \_\_\_\_\_
5. Have you ever been hospitalized for any illness, accident or surgery? \_\_\_\_\_  
If yes, when and why? \_\_\_\_\_
6. Woman: Are you pregnant now? \_\_\_\_\_

**Do you have or have you had any of the following:**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	<u>Unknown</u>
7. Heart Trouble (including heart murmurs, valve, prosthesis/pacemaker)			26. Allergy, hay fever, hives			
8. Rheumatic fever			27. Asthma			
9. High/Low blood pressure			28. Sinus problems			
10. Kidney problems			Are you allergic to or have you had any unusual reactions to the following?			
11. Liver Disease (hepatitis)				Yes	No	Unknown
12. Jaundice			29. Penicillin			
13. Diabetes			30. Dental local			
14. Anemia, Sickle cell, Iron			31. Barbiturates			
15. Prolonged bleeding			32. Codeine or other narcotics			
16. Severe infections			33. Aspirin			
17. Epilepsy			34. Sedatives			
18. Fainting			35. Sulfa			
19. Convulsions			36. Specify other			
20. Pneumonia			Do you have any other disease, condition emotional problems you would like to bring to our attention?			
21. Tuberculosis						
22. Venereal Disease, AIDS, ARC						
23. Latex or vinyl (glove) allergy						
24. Metal Allergies (jewelry, etc.)						
25. Arthritis						

I Hereby consent to the initial examination, including taking of diagnostic radiography's (x-rays), photographs and casts as deemed necessary by Orthodontic Group of the Finger Lakes. I understand that if treatment is not started within 60 days of the initial consultation, I will be billed \$230.00 for diagnostic records taken. If I do begin treatment, the cost of these records will be included in the total treatment cost.

Date \_\_\_\_\_ Signature (self/guardian) \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**FOR DOCTOR'S USE ONLY**

Summary of medical history/ medical problems affecting dental treatment:

\_\_\_\_\_

HX obtained from \_\_\_\_\_ Reviewed by Dr. \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**DENTAL HISTORY**

HAVE YOU EVER HAD THE FOLLOWING TREATMENT:

	YES	NO
Orthodontic (straightening of the teeth) As a child _____, or an adult _____.		
Extractions How long ago _____ Reason for extractions _____		
Periodontal treatment		
Mouthguard or splint (plastic device between your teeth)		
Treatment or surgery to change your bite		

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

Sores, lumps or irritated areas in your mouth		
Food catching or collecting between your teeth		
Clenching or grinding your teeth		
Clicking, popping or grating noise in your jaw when chewing Does it bother you? _____		
Numbness or tingling in your mouth or face		
Would you change anything about your teeth or smile?		

Over the past five years, how often have you been seen for teeth cleaning? \_\_\_\_\_

The date of your last visit to a dentist \_\_\_\_\_.

That dentist's name \_\_\_\_\_

DATE: \_\_\_\_\_ PATIENT SIGNATURE \_\_\_\_\_