Welcome

Scott Stein, D.D.S. ● 585-586-4080
20 N. Main Street ● Pittsford, NY 14534

To Your Orthodontist!

About You

Today's Date: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Cell/other #: (____)_____ Work Phone #: (____)_____ Ext: ____ Driver's License #: _____

E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Present Dentist: _____ Date of last visit: _____ Person Responsible for Account: _____

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: _____ Driver's License #: _____

Insurance Information

Primary Insurance Orthodontic Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Orthodontic Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

Dental History

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

Have you ever been evaluated for ortho treatment? ❑ Yes ❑ No

Have you ever had 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 ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Have your ever had periodontal (gum) surgery or been told that you have periodontal disease by a dentist? ❑ Yes ❑ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have speech problems? _____

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

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

Your Current Dental health? ❑ Good ❑ Fair ❑ Poor

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

If not, what would you change? _____

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 other form? ❑ Yes ❑ No

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

Have you ever been prescribed Fosamax or any bisphosphonate? ❑ Yes ❑ No

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

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Glaucoma	Y N Hospitalized for any Reason	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

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

Authorization

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 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 I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information including diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

I verbally reviewed the medical/dental information with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____