ORTHODONTIC ASSOCIATES OF LITTLE NECK

Orthodontic Associates of Little Neck

Practice Limited to Orthodontics

Little Neck Pkwy
Little Neck, NY 11362
Phone: 718.224.0040
www.littleneckortho.com

Patient Information

Patient's Name: ____ ☐ Male ☐ Female
First Middle Last

Date of Birth: ____/____/____ E-Mail Address: ____________________ ☐ Married ☐ Divorced ☐ Single
Marital Status

Address: ____
Street Town State Zip

How long at this address? __________ Home Phone: (___) __________ Work Phone: (___) __________

Previous Address (if less then 3 yrs.) ______________________________________
Street Town State Zip

Social Security #: ______________ Date of Birth: _____/___/___ Work Phone (___) ____________

Employer: ____________________ Occupation: ______________ No. Years Employed: ______

Spouse's Name: ______________________________ Relationship to Patient: __________
First Middle Last

Employer: ____________________ Occupation: ______________ No. Years Employed: ______

Social Security #: ______________ Date of Birth: ___/___/___ Work Phone: (_____) ____________

Dental Insurance Information

Primary	Secondary
Policy Holder: ______________	Policy Holder: ______________
SS# of Policy Holder: ______________	SS# of Policy Holder: ______________
Policy Holder's Date of Birth: ______/______/_______	Policy Holder's Date of Birth: _______/_______/_________
Insurance Company: ______________	Insurance Company: ______________
Insurance Address: ______________	Insurance Address: ______________
______________	______________
Insurance Group/Policy#: ______________	Insurance Group/Policy#: ______________

- I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to North Shore Orthodontics of the insurance benefits otherwise payable to me.
- I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
- I certify that the above information is complete and true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained.

Signature: ____ Date: ___/____/____

Over

Patient's Medical/Dental History

Patient's Dentist: ________________________________ Phone#: (____) ________________ Last Visit: _________

What is patient's primary concern: ____

____

____

Patient's Physician: _____________________________ Phone#: (_____) ________________ Last Visit: _________

Is patient presently being treated by a physician? Yes No Why?: ____

____

Has the patient's tonsils and adenoids been removed? Yes No

Has the patient ever had an unusual reaction to any drug? Yes No

Does patient have a speech problem, if so are they receiving therapy? Yes No

Has the patient any of the following?

- □ Heart Murmur
- □ Rheumatic Fever
- □ Mitral Valve Prolapse
- □ Pre Medication Required
- □ Anemia
- □ Bleeding Problems
- □ Gum Problems
- □ Tuberculosis
- □ Diabetes
- □ Epilepsy
- □ Convulsions/Seizures
- □ Immune Deficiency
- □ Smoke Cigarettes/Cigars
- □ Asthma
- □ Breathing Problems
- □ Frequent Colds
- □ Sinus Problems
- □ Cold Sores
- □ ADD/ADHD
- □ Ulcers
- □ Thyroid/Hormonal Imbalance
- □ Lip Biting
- □ Nail Biting
- □ Tongue Thrusting
- □ Presently Suck Thumb/Finger
- □ Arthritis
- □ Problems Opening/Closing
- □ Chewing Problems
- □ Jaw Popping
- □ Grinding/Clenching
- □ Concussion
- □ Injury to Teeth/Jaws
- □ Severe Headaches
- □ Facial Pain
- □ Any TMJ History
- □ Nervous Disorder
- □ Hearing Problem
- □ Latex Allergy
- □ Metal Allergy
- □ Seasonal Allergy
- □ Other Allergy: List: ____________ ________________ ________________ ________________
- □ Major Surgery ________________ ________________ ________________

Has Patient ever had orthodontic treatment or worn a retainer? Yes No

Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: _____________________

Names of Daily Medications? ____

Is there any other information about the patient's health we should know? ________________________________

____

____

Whom may we thank for the referring you to our office?

Please check all that apply:

My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List

North Shore Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in: ______________

My Friend/Relative Referred Me (list name(s)): ____

____

Other (please specify): ____

____

____

Signature: ____ Date: ___/____/____

Review by Doctor: ____ Date: ___/____/____