

Welcome To Our Office!

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Diplomate American Board of Orthodontics
Specialty #5308



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Westwood, NJ 07675
201.666.4646

PLEASE TELL US ABOUT YOUR CHILD

Today's Date: _____
Name: _____ MI: _____ Last Name: _____ Nickname: _____
DOB: _____ Age: _____ Gender: _____ Grade: _____ Parent's Cell: _____
Address: _____ City: _____
State: _____ Zip: _____ SS#: _____
Child's hobbies & interests: _____
Other children in the family & ages: _____
Who may we thank for this referral? _____

PARENT/GUARDIAN INFORMATION

Married Divorced Separated Remarried Single

Parent/Guardian 1 - Title: _____ First Name: _____ Last Name: _____
Address (if different): _____ Town: _____ Zip: _____
Email Address: _____ Home Phone: _____ Cell: _____

Parent/Guardian 2 - Title: _____ First Name: _____ Last Name: _____
Address (if different): _____ Town: _____ Zip: _____
Email Address: _____ Cell: _____

RESPONSIBLE PARTY INFORMATION

Person financially responsible for this account: _____
Relationship to Patient: _____
DOB: _____ SS#: _____
Cell Phone: _____
Email Address: _____
Employer: _____
Is it okay to contact you at work? _____ Business Phone: _____

INSURANCE INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Co: _____
Insurance Address: _____
Phone #: _____
Member ID: _____
Group # (plan, local or policy): _____
Subscriber: _____
Relation to Patient: _____
Employer: _____
Birthdate: _____ SS#: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Co: _____
Insurance Address: _____
Phone #: _____
Member ID: _____
Group # (plan, local or policy): _____
Subscriber: _____
Relation to Patient: _____
Employer: _____
Birthdate: _____ SS#: _____

I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination, rendered to my insurance company.

Signature on file for insurance _____ Date _____

MEDICAL AND DENTAL HISTORY

Please answer the following questions to the best of your knowledge

Family/Patient's Dentist: _____ Office Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Name: _____ Office Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

1. Is your child now or has he/she ever been under a physician's care? Yes No
 2. Has your child ever been hospitalized? Yes No REASON _____
 3. Allergies: food, pollen, drugs? Yes No EXPLAIN _____
 4. Any medical problems? Yes No
 Heart Kidneys Lungs Liver Blood Disorders Other _____
 5. Were their tonsils or adenoids removed? Yes No
 6. Has any professional suggested antibiotics (e.g. penicillin) be taken prior to a dental procedure? Yes No
 7. Any recent sudden increase in height? Yes No
 8. Sign of puberty? Yes No (This question helps determine growth potential which could be critical in orthodontic treatment)
 9. What is your main concern in regards to their teeth/bite? _____

 10. Who first suggested the need for an orthodontic consult/treatment?
 Parents Patient Dentist Other _____
 11. Previous orthodontic treatment/consult? Yes No May we ask where _____
 12. Is there clicking/popping/discomfort with the jaw joints? Yes No
 13. Are you aware of any grinding or clenching of teeth? Yes No
 14. Speech or other oral/dental problems? Yes No
 15. When was your last visit to a general dentist?
 Recent 6 or more months ago More than a year ago Don't remember
 16. Gag reflex? Yes No
 17. History of facial /tooth trauma? Yes No If yes, please explain _____

 18. Oral habits: Thumb/Finger sucking Lip/Nail biting Mouth breathing Tongue thrust
- Any other diagnoses you would like to include? _____

*I, the undersigned, give consent to release my information to the emergency contact listed here:

First and Last Name	Relationship to Patient	Contact
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*I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history record, I will so inform this practice. Also, I give consent for this examination and I am legally authorized to do so.

*Today's Date

*Parent/Guardian Signature Required

