BRODSKY ORTHODONTICS

WELCOME TO BRODSKY ORTHODONTICS

PLEASE PRINT AND COMPLETE BOTH THE FRONT & BACK SIDES

DATE: _____

NAME _____ AGE: YEARS _____ MONTHS _____

DATE OF BIRTH _____ SEX _____ WEIGHT _____ HEIGHT _____ E-MAIL ADDRESS _____

ADDRESS _____ CITY _____ ZIP _____

PARENTS ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED PATIENT LIVES WITH _____

MOTHER'S NAME _____ DOB _____

SOCIAL SECURITY NUMBER _____

➤ *Please check which number is the best to reach you during the day*

☐ HOME # _____
☐ WORK # _____
☐ CELL # _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

CITY: _____ ZIP: _____

OCCUPATION: _____

PATIENT'S BROTHERS? NAME _____ AGE _____

NAME _____ AGE _____

FATHER'S NAME _____ DOB _____

SOCIAL SECURITY NUMBER _____

➤ *Please check which number is the best to reach you during the day*

☐ HOME # _____
☐ WORK # _____
☐ CELL # _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

CITY: _____ ZIP: _____

OCCUPATION: _____

PATIENT'S SISTERS? NAME _____ AGE _____

NAME _____ AGE _____

HAS PATIENT EVER BEEN SEEN FOR ANY OTHER ORTHODONTIC CONSULTATION? ---------- YES NO

IF YES, WHO WAS THE ORTHODONTIST(S)? _____ DATE OF VISIT(S) _____

HAS THE PATIENT EVER HAD PREVIOUS ORTHODONTIC TREATMENT? ---------- YES NO

WHO WAS THE ORTHODONTIST? _____ HOW LONG AGO WAS TREATMENT? _____

HAS ANYONE IN YOUR FAMILY HAD ORTHODONTIC TREATMENT IN OUR OFFICE? ---------- YES NO

WHO? Their first & last name and relationship to patient _____

WHOM MAY WE THANK? PLEASE CIRCLE WHO REFERRED YOU TO OUR OFFICE:

DENTIST FAMILY FRIENDS DRIVE BY WEBSITE OTHER

YOUR REFERRAL'S NAME: FIRST _____ LAST _____ RELATIONSHIP TO PATIENT: _____

PRIMARY INSURED INFORMATION

Name of Insured: How does the insured's name appear on the insurance card?

Insured's Birthday: MM/DD/YY SSN: _____

Relationship to Patient: mother, stepfather, grandmother, etc.

Address of Insured: write same if same as patient's address

City: _____ State: _____ Zip: _____

Employed by: _____

Work Address: write same if you have written on this page already

City: _____ State: _____ Zip: _____

Dental Insurance Co. Name: Complete name Ex: Cigna include here if this plan is HMO/PPO

Ins Address: _____

City: _____ State: _____ Zip: _____

Ins Group #: _____ Ins Phone: _____

SECONDARY INSURED INFORMATION

Name of Insured: How does the insured's name appear on the insurance card?

Insured's Birthday: MM/DD/YY SSN: _____

Relationship to Patient: mother, stepfather, grandmother, etc.

Address of Insured: write same if same as patient's address

City: _____ State: _____ Zip: _____

Employed by: _____

Work Address: write same if you have written on this page already

City: _____ State: _____ Zip: _____

Dental Insurance Co. Name: Complete name Ex: Cigna include here if this plan is HMO/PPO

Ins Address: _____

City: _____ State: _____ Zip: _____

Ins Group #: _____ Ins Phone: _____

DIAG RECORDS: $ _____

TREATMENT FEE: $ _____

INSURANCE: $ _____

PERSONAL: $ _____

DOWN PMT: $ _____

MONTHLY PMTS: $ _____

FOR OFFICE USE ONLY

Consult: Dr B C

Refer to: Endo GP OS Perio

Midlines Upper R L _____mm

Lower R L _____mm

TMJ _____

Type: Mini Clear Self-Lig

Treatment: Full
Phase 1 2
Limited
Surgical
Invisalign

Appliances:

Extractions _____

DENTAL HISTORY RECORD

PATIENT NAME:_____

PATIENT'S DENTISTS NAME: FIRST_____ LAST_____ LAST DENTAL APPT._____

DENTIST ADDRESS _____ CITY _____ PHONE ( ) _____

PLEASE CHECK REASONS FOR SEEKING ORTHODONTIC CONSULTATION:

☐ FRONT TEETH PROTRUDING ☐ CROWDED TEETH ☐ SPACES BETWEEN TEETH
☐ OVERBITE/UNDERBITE ☐ JAW PAIN ☐ OTHER _____

Did your dentist encourage you to seek an orthodontic consultation? _____	YES	NO
Do you have any missing or extra permanent teeth? _____	YES	NO
Have you ever been told that you have "gum" problems? _____	YES	NO
Have you ever had any difficulty with past dental treatment? _____	YES	NO
Have you ever had an injury to your face, neck, jaws, or teeth? Explain: _____	YES	NO
Do you have difficulty in opening your mouth wide? _____	YES	NO
Jaws ever click or pop? _____	YES	NO
Do you have pain in the front of the ears? _____	YES	NO
Do you have pre-existing TMJ problems? _____	YES	NO

Check habits:

☐ Nail Biting ☐ Lip Biting ☐ Thumb or Finger Sucking ☐ Pencil Biting ☐ Mouthbreathing
☐ Night Grinding ☐ Other _____

Are you interested in: ☐ Mini (metal) Braces ☐ Clear (ceramic) Braces ☐ Invisalign ☐ Retainers

MEDICAL HISTORY RECORD

Your health is important to us. In order to provide excellent care with safety, it is necessary to become acquainted with vital information related to each patient. Thus, it is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask the doctor or a member of the staff for assistance.

1. Have you been a patient in a hospital during the past 2 years? _____	YES	NO
2. Have you been under the care of a physician during the past 2 years? _____	YES	NO
3. Are you currently taking Fosamax or any Bisphosphonates for osteoporosis or pre-osteoporosis? ____	YES	NO
4. Have you taken any kind of medicine or drugs during the past year? _____	YES	NO

PLEASE LIST THIS MEDICATION:

_____ _____
_____ _____

5. Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Cancer / Chemotherapy	Y N Heart Murmur	Y N Persistent Cough
Y N Anemia	Y N Congenital Heart Lesions	Y N Heart Pacemaker	Y N Psychiatric Treatment
Y N Artificial Bones / Joints	Y N Diabetes	Y N Hemophilia	Y N Radiation Treatment
Y N Artificial Heart Valve	Y N Drug / Alcohol Abuse	Y N Hepatitis	Y N Rheumatic / Scarlet Fever
Y N Asthma	Y N Emphezema	Y N High / Low Blood Pressure	Y N Sinus Problems
Y N AIDS / HIV+	Y N Epilepsy / Seizures / Fainting	Y N Hives / Skin Rash	Y N Tuberculosis
Y N Arthritis	Y N Glaucoma	Y N Kidney, Liver Disease	Y N Ulcers / Colitis
Y N Bronchitis	Y N Heart Attack / Stroke	Y N Mitral Valve Prolapse	Y N Venereal Disease

6. Are you allergic to any of the following?

Y N Any Metals / Plastics	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Please list any other allergies _____	

7. Do you smoke?_____ How much? _____	YES	NO
8. Women: Are you pregnant now?_____How many months? _____	YES	NO
9. Is there a possibility you are pregnant?_____ Are you nursing? _____	YES	NO
10. Do you wear contact lenses? _____	YES	NO
11. Do you suffer from frequent or severe headaches, neck or back pain? _____	YES	NO
12. Have you had any other serious illnesses? _____	YES	NO

13. Physician's Name, City, and Phone Number_____

_____

_____

Reviewed by Dr. Brodsky

Date _____

Signature _____

All the information that I have provided on this form is accurate and current to the best of my knowledge. In addition, I have given permission for Brodsky Orthodontics to use my e-mail address for correspondence by including it on this form

X Signature of Patient (Parent or Guardian, if minor) _____ Date: _____

MEDICAL HISTORY / PHYSICAL EVALUATION UPDATE

Date	*Addition*	*Changes Since Last Update*	
_____	_____	*Y*_____	*N*_____
_____	_____	*Y*_____	*N*_____