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8 Bond Street, Suite 1
Great Neck, New York 11021
Tel: 516-482-9140
Fax: 516-482-4918

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Form No. T303HA

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Date _____

CONFIDENTIAL

Member of the
American Association of Orthodontists

MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Last Name _____ First Name _____ Middle Name/Initial _____

Birth Date _____ Age _____ Sex: Male ❑ Female ❑ I Prefer To Be Called _____

S.S.N. / S.I.N. _____ Home Phone No. _____

Patient's Address _____

City _____ State/Province _____ Zip/Postal Code _____

Patient Attends School At _____ Grade _____

Musical Instruments Played _____

Sports and/or Hobbies _____

No. of Brothers and Sisters _____ Name and Ages _____

Other family members treated here – Name: _____

Has your child seen another orthodontist? Yes ❑ No ❑ Doctor's Name _____

If yes, was any treatment started or completed _____

Person with Patient at this Exam and Relationship _____

Custodial Parent(s) or Guardian(s) _____

Family Status: ❑ Married ❑ Single ❑ Widow ❑ Separated ❑ Divorced

Place of Employment _____ Work No. _____

E-mail address _____ Cell Phone/Pager _____

Who is financially responsible for this account? _____

Last Name _____ First Name _____ Middle Name/Initial _____

Address (if different than Patient's) _____

City _____ State/Province _____ Zip/Postal Code _____

Phone No. (if different than Patient's) _____ S.S.N. / S.I.N. _____

Insurance Coverage for Orthodontic Treatment? Yes ❑ No ❑

Primary Policy Holder's Name _____ S.S.N. / S.I.N. _____

Birth Date _____ Employed By _____

Dental Insurance Company _____ Group No. _____

Name of Patient's Dentist _____

Phone No. _____

Dentist's Address _____

City _____ State/Province _____ Zip/Postal Code _____

Date Last Seen _____ Reason _____

Name of Patient's Physician(s) _____

Phone No.(s) _____

Physician's Address _____

City _____ State/Province _____ Zip/Postal Code _____

Date Last Seen _____ Reason _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? Office Staff Member ❑ Dentist ❑ Phone Book ❑ Friend ❑ Name _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

❑ Yes ❑ No ❑ dk/u Does patient follow directions well?

❑ Yes ❑ No ❑ dk/u Does patient brush his/her teeth conscientiously?

❑ Yes ❑ No ❑ dk/u Does patient have learning disabilities or need extra help with instructions?

❑ Yes ❑ No ❑ dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, has patient had:

❑ Yes ❑ No ❑ dk/u Birth defects or hereditary problems?

❑ Yes ❑ No ❑ dk/u Bone fractures, any major accidents?

❑ Yes ❑ No ❑ dk/u Rhematoid or arthritic conditions?

❑ Yes ❑ No ❑ dk/u Endocrine or thyroid problems?

❑ Yes ❑ No ❑ dk/u Kidney problems?

❑ Yes ❑ No ❑ dk/u Diabetes?

❑ Yes ❑ No ❑ dk/u Cancer, tumor, radiation treatment or chemotherapy?

❑ Yes ❑ No ❑ dk/u Stomach ulcer or hyperacidity?

❑ Yes ❑ No ❑ dk/u Polio, mononucleosis, tuberculosis, pneumonia?

❑ Yes ❑ No ❑ dk/u Problems of the immune system?

❑ Yes ❑ No ❑ dk/u AIDS or HIV positive?

❑ Yes ❑ No ❑ dk/u Hepatitis, jaundice or liver problem?

❑ Yes ❑ No ❑ dk/u Fainting spells, seizures, epilepsy or neurological problem?

❑ Yes ❑ No ❑ dk/u Mental health disturbance or depression?

❑ Yes ❑ No ❑ dk/u Vision, hearing, talking or speech difficulties?

❑ Yes ❑ No ❑ dk/u Loss of weight recently, poor appetite?

❑ Yes ❑ No ❑ dk/u History of eating disorder (anorexia, bulimia)?

❑ Yes ❑ No ❑ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

❑ Yes ❑ No ❑ dk/u High or low blood pressure?

❑ Yes ❑ No ❑ dk/u Tired easily?

❑ Yes ❑ No ❑ dk/u Chest pain, shortness of breath or swelling ankles?

❑ Yes ❑ No ❑ dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

❑ Yes ❑ No ❑ dk/u Skin disorder?

❑ Yes ❑ No ❑ dk/u Do you have a well-balanced diet?

❑ Yes ❑ No ❑ dk/u Frequent headaches, colds or sore throats?

❑ Yes ❑ No ❑ dk/u Eye, ear, nose or throat condition?

❑ Yes ❑ No ❑ dk/u Hayfever, asthma, sinus trouble or hives?

❑ Yes ❑ No ❑ dk/u Tonsil or adenoid conditions?

❑ Yes ❑ No ❑ dk/u Osteoporosis?

Allergies or reactions to any of the following:

❑ Yes ❑ No ❑ dk/u Local anesthestics (Novocaine or Lidocaine)

❑ Yes ❑ No ❑ dk/u Aspirin

❑ Yes ❑ No ❑ dk/u Ibuprofen (Motrin, Advil)

❑ Yes ❑ No ❑ dk/u Penicillin or other antibiotics

❑ Yes ❑ No ❑ dk/u Sulfa drugs

❑ Yes ❑ No ❑ dk/u Codeine or other narcotics

❑ Yes ❑ No ❑ dk/u Metals (jewelry, clothing snaps)

❑ Yes ❑ No ❑ dk/u Latex (gloves, balloons)

❑ Yes ❑ No ❑ dk/u Vinyl

❑ Yes ❑ No ❑ dk/u Acrylic

❑ Yes ❑ No ❑ dk/u Animals

❑ Yes ❑ No ❑ dk/u Foods (specify) _____

❑ Yes ❑ No ❑ dk/u Other substances (specify) _____

❑ Yes ❑ No ❑ dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Health History Form

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

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Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐

	Yes	No	DK
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments: _____