Allsmiles Orthodontic Associates
Practice Limited to Orthodontics

232 Orinoco Drive
Brightwaters, NY 11718
Phone: (631) 666-7008
www.goallsmiles.com

Patient Information

Patient's Name: _____ □ Male □ Female
First Middle Last

Date of Birth: ____/____/____

Address: _____
Street Town State Zip

If Patient is a minor, give parent's/guardian's name(s): _____

Names/Ages of brothers and sisters: _____

_____

Responsible Party Information

Name: _____ □ Married □ Divorced □ Single
First Middle Last Marital Status

Custodial Parent: □ Mother □ Father □ Both E-Mail Address: _____

Address: _____
Street Town State Zip

How long at this address? _____ Home Phone: (___) _____ Cell 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 the 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 Island 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 (Parent's if minor): _____ Date: ___/____/____

Over

Patient's Medical/Dental History

Patient's Dentist: _____ Phone#: (____) _____ Last Visit: _____

What is patient's/parent's primary concern: _____

_____

_____

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

Is the patient presently being treated by a physician? Yes/No Why?: _____

_____

Has the patient's tonsils and adenoids been removed? Yes/No Is child adopted? Yes/No

Has the patient ever had an unusual reaction to any drug? Yes/No Is child aware of adoption? Yes/No

Does the patient have a speech problem? Yes/No If so, are they receiving therapy? Yes/No

Does the patient have 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 the 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: _____

If Female: Menstruating? Yes/No Date of First Period: ___/___/___

If Male: Voice Change? Yes/No Date Started: ___/___/___ Shaving? Yes/No Date Started: ___/___/___

Names of Daily Medications? _____

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

_____

_____

Whom may we thank for referring you to our office?

Please circle all that apply:

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

Allsmiles Website Invisalign Website Yellow Page Ad Newspaper Ad in: _____

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

_____

Other (please specify): _____

_____

_____

Signature (Parent's if minor): _____ Date: ___/____/____

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