SCOTIA ORTHODONTICS
SMILE WITH CONFIDENCE

PATIENT INFORMATION

Name _____ M F DOB_____

Address (street,town,zip)_____
_____

Email_____
Will be kept confidential
Home Phone_____ Cell Phone_____ Work Phone_____
Social Security #_____ How did you hear about our office: friend relative dentist internet theater video
General Dentist_____ Last Visited_____ Occupation_____
Have we treated another family member? YES NO If YES, Name_____
First Last
Have you visited an orthodontist before? YES NO If YES, for what reason?_____
Is there anything you would like to discuss with the doctor in private? YES NO
School_____ Interests/Hobbies_____

RESPONSIBLE PARTY and INSURANCE INFORMATION

CIRCLE Self Father Mother Step Parent Spouse Other_____
Marital status: Single Married Widowed Divorced Separated Partner
Name_____ Email_____
Address if different than child's_____ Birth Day_____
Home Phone_____ Cell Phone _____Work Phone_____ SS#_____
PRIMARY*: If you have orthodontic/dental insurance:* Employer_____
Insurance Co_____ _____ _____
ID#_____ ____Plan #_____ _____

CIRCLE Self Father Mother Step Parent Spouse Other_____
Marital status: Single Married Widowed Divorced Separated Partner
Name_____ Email_____
Address if different than child's_____ Birth Day_____
Home Phone_____ Cell Phone _____Work Phone_____ SS#_____
SECONDARY*: If you have orthodontic/dental insurance:* Employer_____
Insurance Co_____ _____ _____
ID # _____Plan #_____

CIRCLE Self Father Mother Step Parent Spouse Other_____
Marital status: Single Married Widowed Divorced Separated Partner
Name_____ Email_____
Address if different than child's_____ Birth Day_____
Home Phone_____ Cell Phone _____Work Phone_____ SS#_____
OTHER*: If you have orthodontic/dental insurance:* Employer_____
Insurance Co_____ _____
ID # _____Plan #_____

207 Mohawk Avenue. Suite 1A. Scotia, NY 12302
P: (518)372-3424 **Email:** info@scotiaortho.com
www.scotiaortho.com

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Patient Name:_____ «MEDICAL HISTORY

Is the patient in good health? Circle One YES NO Describe_____
Is patient taking prescriptions or over the counter medications? YES NO Please list all prescriptions and medications:
_____
If female, is the patient pregnant or possibly pregnant? YES NO
Under the care of a physician? YES NO Explain:_____
Physician name and phone number:_____
History of major illness? YES NO Describe:_____
Any sensitivities or allergies? YES NO List:_____
Have tonsils and/or adenoids been removed? YES NO When?_____
Any condition not listed that you would like the doctor to know about?_____
Has the patient had any of the following medical conditions? Please circle YES of NO

YES NO **ADD/ADHD**	YES NO **CANCER**	YES NO **HERPES**	YES NO **OSTEOPOROSIS/ OSTEOPENIA**
YES NO **AUTISM SPECTRUM**	YES NO **COLD SORES**	YES NO **HEART MURMUR**	YES NO **PNUEMONIA**
YES NO **AIDS/ARC**	YES NO **DIABETES**	YES NO **HEART CONDITION**	YES NO **PSYCHIATRIC PROBLEM**
YES NO **ANEMIA**	YES NO **DIZZY SPELLS**	YES NO **KIDNEY PROBLEM**	YES NO **RADIATION TREATMENT**
YES NO **ANGINA**	YES NO **EPILEPSY**	YES NO **LIVER PROBLEM**	YES NO **RHEUMATIC FEVER**
YES NO **ARTHRITIS**	YES NO **FAINTING**	YES NO **HIGH BLOOD PRESSURE**	YES NO **TUBERCULOSIS**
YES NO **ASTHMA**	YES NO **FEVER BLISTERS**	YES NO **LOW BLOOD PRESSURE**	YES NO **ULCERS/COLITIS**
YES NO **BLOOD DISORDER**	YES NO **GI DISORDERS**	YES NO **LYME DISEASE**	YES NO **SNORING**
YES NO **BONE DISORDER**	YES NO **HEADACHES**	YES NO **NERVOUS DISORDER**	YES NO **OBSTRUCTIVE SLEEP APNEA**

DENTAL HISTORY

Main orthodontic concern_____
Injuries to the face, mouth, or chin? YES NO Explain:_____
Pain/tenderness/locking of the jaw joint? YES NO Explain:_____
Concerning the following habits please circle YES or NO:

YES NO **Chewing/Eating problem**	YES NO **Nail biting**	YES NO **Clenching and/or grinding**
YES NO **Lip biting**	YES NO **Pen/Pencil biting**	YES NO **Tongue Thrusting**
YES NO **Mouth breathing**	YES NO **Speech Problems**	YES NO **Thumb/Finger sucking**

SIGNATURE

I believe the information I have provided is correct to the best of my knowledge, that it will held in strict confidence and it is my responsibility to inform this office of any changes in my or my child's medical status.

I hereby authorize release of information related to insurance claims. I consent to examination by the doctor and I authorize payment of insurance benefits.
Signature_____Date_____

Patient/Parent/Guardian yearly review
12 month_____24 month_____36 month_____

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