CENTRAL NEW YORK ORTHODONTICS PATIENT INFORMATION FORM

PATIENT'S NUMBER:_____ AGE: _____

BIRTH DATE:_____ SEX:_____ PREFERRED PRONOUNS:_____

PATIENT'S NAME: _____ PATIENT'S NICKNAME_____

HOME ADDRESS: _____HOME PHONE:_____

CITY / STATE_____ZIP:_____

PATIENT E-MAIL ADDRESS:_____

RESPONSIBLE PARTY:_____ SSN#_____ DOB:_____

RESPONSIBLE PARTY ADDRESS:_____ RELATIONSHIP_____

PHONE:_____Cell#_____

RESPONSIBLE PARTY E-MAIL ADDRESS: _____

EMPLOYER:_____WORK PHONE_____

RESPONSIBLE PARTY:_____SSN#_____DOB:_____

RESPONSIBLE PARTY ADDRESS:_____ RELATIONSHIP_____

PHONE_____CELL:_____ok to text? Y or N

RESPONSIBLE EMPLOYER:_____WORK PHONE:_____

RESPONSIBLE PARTY E-MAIL ADDRESS:_____Ok to email? Y or N

HAVE WE TREATED OTHER MEMBER'S OF THE FAMILY?_____WHO?_____

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT? YES NO

FAMILY DENTIST:_____ FAMILY PHYSICIAN:_____

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE:_____

MEDICAL HISTORY:

PATIENTS CURRENT PHYSICAL HEALTH IS: GOOD FAIR POOR

IS PATIENT CURRENTLY UNDER THE CARE OF A PHYSICIAN? NO YES

IS PATIENT TAKING ANY PRESCRIPTION/OVER THE COUNTER DRUGS? NO YES
YES, PLEASE LIST_____

HAS PATIENT EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	HEART ATTACK / STROKE	Y	N	PSYCHIATRIC PROBLEMS
Y	N	CANCER CHEMOTHERAPY	Y	N	EPILEPSY
Y	N	HEART MURMUR	Y	N	FAINTING
Y	N	RHEUMATIC FEVER	Y	N	SEIZURES
Y	N	HIGH BLOOD PRESSURE	Y	N	TUBERCULOSIS
Y	N	LOW BLOOD PRESSURE	Y	N	DIABETES
Y	N	HEPATITIS	Y	N	DRUG / ALCOHOL ABUSE
Y	N	HEART SURGERY / PACEMAKER	Y	N	HEMOPHILIA
Y	N	MITRAL VALVE PROLAPSE	Y	N	ABNORMAL BLEEDING
Y	N	KIDNEY PROBLEMS	Y	N	CONGENITAL HEART DEFECT
Y	N	ARTIFICIAL VALVES	Y	N	RADIATION TREATMENT
Y	N	SINUS PROBLEMS	Y	N	ASTHMA
Y	N	SEVER / FREQUENT HEADACHES	Y	N	EMPHYSEMA
Y	N	HIV+/AIDS	Y	N	DIFFICULTY BREATHING

PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS (S) THAT PATIENT HAS EVER HAD:

_____

HAS PATIENT EVER HAD THEIR TONSILS OR ADENOIDS REMOVED? Y N
WHAT AGE?____

HAS PATIENT EVER HAD SPEECH THERAPY? Y N WHAT AGE_____

DID PATIENT EVER HAVE A THUMB/FINGER HABIT? Y N STOPPED AT WHAT AGE?_____

DOES PATIENT BREATHE THROUGH THEIR MOUTH OR NOSE?_____

DOES PATIENT SNORE?_____

FOR WOMEN: IS PATIENT PREGNANT? NO YES

IS PATIENT ALLERGIC TO ANY OF THE FOLLOWING?

PENICILLIN TETRACYCLINE LATEX ASPIRIN DENTAL ANESTHETICS

ERYTHROMYCIN CODEINE OTHER:_____

IS PATIENT REQUIRED TO TAKE ANTIBIOTICS PRIOR TO DENTAL CLEANINGS? Y N

_____
SIGNATURE OF PARENT/GUARDIAN DATE

**IF THERE ARE ANY CHANGES IN THE ABOVE INFORMATION PLEASE ALERT OUR STAFF IMMEDIATELY.*

By providing your phone number and email address you will automatically receive appointment reminders, and office communication via Text/Email or Voice mail, from our automated system you may opt out at any time.

Do you agree to texting as a form of communication beyond automated reminders? Y or N
Do you agree to email as a form of communication beyond automated reminders? Y or N