HUDSON RIVER ORTHODONTICS, PC
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smiles@hudsonriverortho.com

ADULT PATIENT INFORMATION

Date____________________

Patient's name ____
Last First Middle

Address ____
Street City State Zip

Home phone________________________ Work phone____________________ Date of Birth___________________

Employer___________________________________ Occupation___________________ No. years employed ______

Confirmations and reminders are sent through email and text:

Email Address____ Cell phone _______________________________

Circle cell carrier: **Verizon T-Mobile AT&T MetroPCS Sprint Virgin Nextel Bellsouth Other**:__________

☐ I consent to the dental practice using my cell phone to call or text regarding appointments and to call regarding treatment, insurance and my account

Whom may we thank for referring you to our office? ____

DENTAL INSURANCE INFORMATION

Insurance Company___________________________ Insured's Name___________________________________

Insured's Social Security # or Member ID # ___________________________________ DOB: __________________

Group #______________ Group Name/ Employer ____________________ Insurance phone ___________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insurance Company ___________________________ Insured's Name _____________________________________

Insured's SSN or Member ID # ____ DOB: __________________

Group #______________ Group Name/ Employer _____________________ Insurance phone __________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Complete address ____
Street City Zip

Phone____

MEDICAL HISTORY

Physician ____ Date of Last Visit ____________________________
Address ____ Phone_______________________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____
Yes No Are you allergic to any medication? ____
Yes No Do you have a history of a major illness? ____
Yes No Have you had any operations? ____
Yes No Have you ever been involved in a serious accident? _______________________________________
Yes No Have you ever smoked or chewed tobacco? ____
Yes No Have seen a physician in the last 12 months? Why? ____
Female Patients only:
Yes No Are you pregnant? ____
Yes No Has menstruation started? ____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? __________________________
____

DENTAL HISTORY

General Dentist _______________________________________ Phone and Address __________________________________
____ Date of last visit ____________________

What concerns you most about your teeth? ____

Yes No Are you presently in any dental pain? ____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____________________________
Yes No Have your wisdom teeth been removed? ____
Yes No Have you ever lost or chipped any teeth? ____
Yes No Have there been any injuries to face, mouth, or teeth? ____
Yes No Is any part of your mouth sensitive to temperature? Where? ____________________________________
Yes No Is any part of your mouth sensitive to pressure? Where? _______________________________________
Yes No Do your gums bleed when you brush? ____
Yes No Do you have any type of thumb or tongue habit? ____
Yes No Are you a mouth breather? ____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____________________________________
What is your attitude toward receiving orthodontic treatment? ____
Yes No Has anyone in your family received orthodontic treatment? _______________________________________
How did they feel about the result? ____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____________________
Yes No Are you aware of your jaw clicking or popping? ____
Yes No Are you aware of clenching your teeth during the day? ____
Yes No Have you ever been told that you grind your teeth? ____
Yes No Do you have “tension” headaches? ____
Yes No Have you ever experienced chronic ringing in your ears? ______________________________________
Yes No Are you aware that some appointments will be during work hours? _________________________________

Authorization

I understand that the above information is needed to provide appropriate orthodontic treatment in a safe and efficient manner. All the questions above have been answered accurately to the best of my knowledge. Should any further information be needed, Hudson River Orthodontics, PC has my permission to ask the respective health care provider or agency. I will immediately inform Hudson River Orthodontics, PC of any changes in my health status or use of medications.

I authorize the use of my signature on all insurance submissions and I authorize Hudson River Orthodontics, PC to release all information needed to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. **Also, notice of HIPPA Privacy Policy has been reviewed and explained to me.**

Signature: ____ Date: ____________________