HUDSON RIVER ORTHODONTICS, PC
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PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date___________________

Patient's name____
Last First Middle
Address____
Street City State Zip
Nickname___________________ Sports/Hobbies ___________________________________ Date of Birth____________________

School_____________________________ Parent or guardian name____

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? ____

RESPONSIBLE PARTY INFORMATION

Name ____
Last First Middle
Address ____
Street City State Zip
Home phone_________________________ Cell phone ________________________ Work phone ___________________________
Relationship to Patient ________________ Email address____
Employer____________________________________ Occupation___________________ No. years employed________________

Spouse's Name____
Relationship to Patient___________________________________ Phone # _____________________________________

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_____

EMERGENCY INFORMATION

Name of nearest relative not living with you ____ phone____________________

Complete address ____

MEDICAL HISTORY

Physician ____ Date of Last Visit ___________________________
Address ____ Phone ___________________________________

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

Yes No Is the patient taking any medication? ____
Yes No Is the patient allergic to any medication? ____
Yes No History of a major illness?____
Yes No Has the patient had any operations?____
Yes No Ever been involved in a serious accident?____
Yes No Have seen a physician in the last 12 months? Why? ____________________________________
Female Patients only:
Yes No Has menstruation started? ____
Yes No Is the patient pregnant? ____

Circle any of the medical conditions below that the patient has had or currently has.

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 _____________________________________ Address and phone ______________________________
____ Date of last visit ___________________
What concerns you most about your teeth? ____

Yes No Is the patient presently in any dental pain? ____
Yes No Ever experienced any unfavorable reaction to dentistry? ___________________________________
Yes No Has the patient 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 gums bleed when brushing? ____
Yes No Any type of thumb or tongue habit? ____
Yes No Is the patient a mouth breather? ____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? ___________________________
What is the patient's attitude toward receiving orthodontic treatment? ____________________________
Yes No Has anyone in the family received orthodontic treatment? _________________________________
How did they feel about the result? ____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?___________________________
Yes No Experience jaw clicking or popping? ____
Yes No Aware of clenching or grinding teeth during the day?______________________________________
Yes No Experience "tension" headaches?____
Yes No Has the patient ever experienced chronic ringing in the ears? ______________________________
Yes No Does the patient need extra help with instructions? _______________________________________
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____________________________
Height of parents? Mom________ Dad_________
Yes No Are you aware that some appointments will be during school 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:___________________