

# ORTHODONTIC ASSOCIATES OF WESTCHESTER

## Patient Information

Date \_\_\_\_\_ Patient's Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Patient Social Security # \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Patients Date of Birth \_\_\_\_\_

Parent or Guardian's name if patient a minor \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Responsible Party Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Marital Status \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of years employed \_\_\_\_\_

## Primary Insurance

Insured Name \_\_\_\_\_ Insured Social Security # \_\_\_\_\_ Insured DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Secondary Insurance

Insured Name \_\_\_\_\_ Insured Social Security # \_\_\_\_\_ Insured DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Emergency Information In case of an emergency who shall we contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Name \_\_\_\_\_

### Medical History

Has the patient had any of the following:

Rheumatic Fever \_\_\_\_\_ Heart Problems \_\_\_\_\_ Jaw Pains \_\_\_\_\_  
Arthritis \_\_\_\_\_ Stomach Ulcers \_\_\_\_\_ Respiratory Problems \_\_\_\_\_  
Recent Weight Loss \_\_\_\_\_ Abnormal Bleeding \_\_\_\_\_  
Allergies \_\_\_\_\_ Please List \_\_\_\_\_  
Any Other Major Illnesses? \_\_\_\_\_  
Present Health Condition: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_  
Presently Under Any Medications? Please List \_\_\_\_\_

Your Family Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Your Family Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Any Major Falls, Accidents, or Operations? Yes or No  
If Yes, Please List \_\_\_\_\_  
Any Complaint of "Clicking of Jaw"? Yes or No  
Any Pain When Opening or Closing Mouth? Yes or No  
Any Speech Therapy? Yes or No  
Any Finger or Thumb Habit? Yes or No  
If Yes, Until What Age? \_\_\_\_\_ Any Other Habits? \_\_\_\_\_

Have You Been Examined or Treated by an Orthodontist Before? \_\_\_\_\_  
When? \_\_\_\_\_ Where? \_\_\_\_\_

In Your Own Words, What is the Problem? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signature \_\_\_\_\_