



Confidential Patient Form

Medical & Dental History

For adult patients (age 18 and older)

Please complete this form before your visit. Type into the boxes on your computer, or print it and fill it out by hand. Bring it to your appointment, or use the secure online version on our New Patients page. Questions? Call (718) 238-9888.

Keeping Your Information Private

Do not email this form, text it, or send photos of it; these are not secure for health information. On a shared or public computer, print it without saving, then delete the download. Afterward, delete any filled-in copies saved on your device.

Patient Information

Date	Social Security #	Birth date
Patient's last name	First name	Middle initial
Title	I prefer to be called	
☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Other		
What is your gender?	Marital status	
☐ Male ☐ Female	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Home address	City, State, Zip code	
Cell phone	Home phone	Work phone
E-mail address(es)	Occupation	Employer

Closest Relative

Spouse or closest relative's name(s)	Relationship to patient	
Title	Prefers to be called	
☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Other		
Address (if different than patient address)		
Cell phone	Home phone	Work phone

Financial Responsibility

Who is financially responsible for this account?

Employer

Address

City, State, Zip

Cell phone

Home phone

E-mail address(es)

Social Security #

Dental Insurance

Primary policy holder's full name

Birth date

Social Security #

Relationship to patient

Address and phone (if not listed above)

Employer

Address

Insurance company

Group #

ID #

Does this policy have orthodontic benefits?

☐ Yes ☐ No ☐ Don't know

Secondary policy holder's full name

Birth date

Social Security #

Relationship to patient

Address and phone (if not listed above)

Employer

Address

Insurance company

Group #

ID #

Does this policy have orthodontic benefits?

☐ Yes ☐ No ☐ Don't know

Medical Insurance

Policy holder's full name

Insurance company

Dentist

Patient's dentist

Address, City, State

Last seen

Reason

Next appointment

Other dentists/dental specialists now being seen:

Name

City, State

Reason

Physician

Patient's physician	City, State	Last seen
Reason	Next appointment	Most recent physical exam

Other physicians/health care providers being seen now:

Name	City, State	Reason
Name	City, State	Reason

General Information

What concerns you about your teeth?

Who suggested that you might need orthodontic treatment?

Why did you select our office?

Have you had any previous orthodontic treatment? Please describe.

Have any other family members been treated in this office? Please name them.

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain.

Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Medication	Taken for	Medication	Taken for
Medication	Taken for	Medication	Taken for

Have you ever taken any medications to strengthen your bones? Please describe.

Do you or have you ever had a substance abuse problem?	Do you currently suffer with, or have you suffered in the past with an eating disorder?

Have you chewed tobacco?

☐ Yes ☐ No

Smoked any substance or vaped?

☐ Yes ☐ No

If yes, what is the frequency?

Have you noticed any changes in your face or jaws?

Any other physical problems?

How often do you brush?

How often do you floss?

Are you pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (DK/U).

Medical History

Now or in the past, have you had:

Yes	No	DK/U		Yes	No	DK/U	
☐	☐	☐	Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate)?	☐	☐	☐	Hepatitis, jaundice or other liver problem?
☐	☐	☐	Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?	☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Hereditary or developmental conditions?	☐	☐	☐	Seizures, fainting spells, neurologic problem?
☐	☐	☐	Bone fractures, or major injuries?	☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	Any injuries to face, head, neck?	☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	Arthritis or joint problems?	☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	Endocrine or thyroid problems?	☐	☐	☐	Have you experienced any weight change in the past several months?
☐	☐	☐	Diabetes or low sugar?	☐	☐	☐	High or low blood pressure?
☐	☐	☐	Kidney problems?	☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?	☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?	☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Immune system problems?	☐	☐	☐	Angina, arteriosclerosis, stroke or heart attack?
☐	☐	☐	History of osteoporosis?	☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Gonorrhea, syphilis, herpes, sexually transmitted diseases?	☐	☐	☐	Do you eat a well-balanced diet?
☐	☐	☐	AIDS or HIV positive?	☐	☐	☐	Frequent headaches or migraines?
				☐	☐	☐	Frequent ear infections, colds, throat infections?
				☐	☐	☐	Asthma, sinus problems, hayfever?
				☐	☐	☐	Tonsil or adenoid condition?
				☐	☐	☐	Do you frequently breathe through your mouth?

Allergies

Have you had allergies or reactions to any of the following:

Yes	No	DK/U		Yes	No	DK/U	
☐	☐	☐	Latex (gloves, balloons)	☐	☐	☐	Aspirin
☐	☐	☐	Metals (jewelry, clothing snaps)	☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Acrylics	☐	☐	☐	Penicillin
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)	☐	☐	☐	Other antibiotics
				☐	☐	☐	Plant pollens

Dental History

Now or in the past, have you had:

Yes	No	DK/U		Yes	No	DK/U	
☐	☐	☐	Permanent or extra (supernumerary) teeth removed?	☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc.)?
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?	☐	☐	☐	Teeth causing irritation to lip, cheek or gums?
☐	☐	☐	Chipped or injured primary or permanent teeth?	☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	Any sensitive or sore teeth?	☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?	☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Jaw fractures, cysts, infections?	☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?	☐	☐	☐	ringing in ears, difficulty in chewing or opening jaw?
☐	☐	☐	"Gum boils," frequent canker sores or cold sores?	☐	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	History of speech problems or speech therapy?	☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Difficulty breathing through nose?	☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Food impaction between the teeth?	☐	☐	☐	Have you ever been diagnosed with gum disease or pyorrhea?
☐	☐	☐	Mouth breathing habit or snoring at night?	☐	☐	☐	Have you ever had an orthodontic consultation or treatment before now?
☐	☐	☐	History of speech problems?				

Family Medical History

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders	Diabetes	Arthritis
Severe allergies	Unusual dental problems	Jaw size imbalance
Other family medical conditions?		

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature	Date

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature

Date

Medical History Updates or Changes

For use at later visits.

Changes

Patient Signature

Date

Dental Staff Signature

Date

Changes

Patient Signature

Date

Dental Staff Signature

Date

Changes

Patient Signature

Date

Dental Staff Signature

Date