Natalie Bitton, DDS
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Rockville Centre, New York 11570
phone: **516.766.0012**
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Date _____

Patient Information

Name _____
Last First Preferred Name Middle Sex

Address _____ Marital Status _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security# _____ Home Phone _____

General Dentist _____ Last Visited _____

Who may we thank for referring you to our office? _____

Spouse/Additional Contact Information

Name _____
Last First Middle Marital Status

Address _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Social Security# _____

Policy Owner's Birthdate _____ Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Secondary Insurance

Policy Owner's Name _____ Policy Owner's Social Security# _____

Policy Owner's Birthdate _____ Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Medical History

Are you under the care of a physician? ☐ Yes ☐ No If yes, explain _____

Physician _____ Phone _____ Last Visit _____

Address _____

Are you pregnant? ☐ Yes ☐ No If so, how many weeks _____

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Tetracycline ☐ Any Metals/Plastics ☐ Other Allergies/Sensitivities

☐ Erythromycin ☐ Penicillin ☐ Latex

List all medications you are currently taking

List any serious medical condition(s) treated

Dental History

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have your tonsils or adenoids been removed? ☐ Yes ☐ No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☐ No If Yes, explain _____

Do your gums bleed? ☐ Yes ☐ No Do you smoke/use tobacco ? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Do/Have you ever had any of the following habits?

☐ Lip Sucking/Biting ☐ Nail Biting ☐ Prolonged Bottle/Pacifier ☐ Clenching/Grinding Teeth

☐ Mouth Breather ☐ Tongue Thrusting ☐ Thumb/Finger Sucking

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to this office. I understand that where appropriate, credit bureau reports may be obtained.

Signature of patient _____ Date _____