

## Scott Friedman, D.D.S. Efraim Zak, D.D.S. Randy Weinstein, D.D.S.

Practice Limited to Orthodontics

Whitestone, New York 11357 Phone: (718) 746-8900 www.BraceMan.COM

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			www.braccman.com
Patient Information			- Mala - Famala
Patient's Name:	Middle	Last	Male   Female
Date of Birth:/	wildate	Last	
Address:			
Address: Street	Town	State	Zip
If Patient is a minor, give parent's/guardie			
Names/Ages of brothers and sisters:			
<b>Responsible Party Information</b>			
		□ Married	□ Divorced □ Single
Name: Mid			Marital Status
Custodial Parent: $\Box$ Mother $\Box$ Father $\Box$ Bo	oth E-Mail Address:		_
Address:Street			
Street	Town	State	Zip
How long at this address?	Home Phone: ()	Work Phone:	()
Previous Address (if less then 3 yrs.)			
	Street		Zip
Social Security #:	Date of Birth:/	_/ Work Phone () _	
Employer:	Occupation:	No. Year	rs Employed:
Spouse's Name:		Relationship to Pati	ent:
	dle Last	NI 37	г 1 1
Employer:	Occupation:	No. Year	rs Employea:
Social Security #:	Date of Birth://	work Phone: () _	
<b>Dental Insurance Information</b>			
Primary	Secondary		
		or:	
Policy Holder:	Folicy field	er:	
SS# of Policy Holder:		ey Holder:	1
Policy Holder's Date of Birth:/_	/Policy Holds	er's Date of Birth:	/
Insurance Company:	Insurance C	ompany:	
Insurance Address:	Insurance A	ddress:	
Insurance Group/Policy#:	Insurance G	roup/Policy#:	
• I hereby authorize release of any	information to other health	care providers, insurance	companies,
and business associates includ			
which is not strictly dental or			
North Shore Orthodontics of the			ancerry to
• I am giving my consent to your		1 2	o carry out
treatment, payment activities and		occica nearm information t	o carry out
		are to the best of my lan	avuladas I
• I certify that the above inform			owieage. I
understand that where appropria	ite, credit bureau reports ma	y be obtained.	
Signatura (Darant's if min an).			Data: / /
Signature (Parent's if minor):			Date:/

□ Rheumatic Fever □ Breathing Problems □ Problems Opening/Closing □ Metal □ Mitral Valve Prolapse □ Frequent Colds □ Chewing Problems □ Seaso □ Pre Medication Required □ Sinus Problems □ Jaw Popping □ Other □ Anemia □ Cold Sores □ Grinding/Clenching □ List: □ Bleeding Problems □ ADD/ADHD □ Concussion □ List: □ Gum Problems □ Ulcers □ Injury to Teeth/Jaws □ Tuberculosis □ Thyroid/Hormonal Imbalance □ Severe Headaches □ Lip Biting □ Racial Pain □ Major □ Epilepsy □ Nail Biting □ Any TMJ History □ Convulsions/Seizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars □ Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: □ If Female: Menstruating? Yes No Date of First Period: □ /	Patient's Medical/Dental H Patient's Dentist:		none#: ()	Last Visit:
Has the patient's tonsils and adenoids been removed? Yes No Is child adopted? Yes No Bas the patient ever had an unusual reaction to any drug? Yes No Is child adopted? Yes No Does patient have a speech problem, if so are they receiving therapy? Yes No Has the patient any of the following?    Heart Murmur	What is patient's/parent's pri	imary concern:		
Has the patient's tonsils and adenoids been removed? Yes No	Oationt's Dhysician	Dha	one#: ( )	Lact Vicit
Has the patient ever had an unusual reaction to any drug? Yes No Does patient have a speech problem, if so are they receiving therapy? Yes No Has the patient any of the following?    Heart Murmur	s patient presently being trea	ated by a physician? Yes No	Why?:	Last visit.
Has the patient ever had an unusual reaction to any drug? Yes No Does patient have a speech problem, if so are they receiving therapy? Yes No Has the patient any of the following?    Heart Murmur				
Does patient have a speech problem, if so are they receiving therapy? Yes No  Has the patient any of the following?    Heart Murmur	=			
Has the patient any of the following?    Heart Murmur	-			re of adoption? Yes No
Heart Murmur			tnerapy? Yes No	
□ Rheumatic Fever □ Breathing Problems □ Problems Opening/Closing □ Metal □ Mitral Valve Prolapse □ Frequent Colds □ Chewing Problems □ Seaso □ Pre Medication Required □ Sinus Problems □ Cold Sores □ Grinding/Clenching □ Sinus Problems □ Cold Sores □ Grinding/Clenching □ List: □ Concussion □ Gum Problems □ Ulcers □ Injury to Teeth/Jaws □ Tuberculosis □ Thyroid/Hormonal Imbalance □ Severe Headaches □ Diabetes □ Lip Biting □ Facial Pain □ Major □ Epilepsy □ Nail Biting □ Reroid Pain □ Major □ Convulsions/Seizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: □ Fermale: Menstruating? Yes No Date of First Period: □ /		_	_ A41'4: -	— I -4 All
Mitral Valve Prolapse   Frequent Colds   Chewing Problems   Sauso Pro Medication Required   Sinus Problems   Jaw Popping   Other				□ Latex Allergy
□ Pre Medication Required □ Sinus Problems □ Jaw Popping □ Other □ Anomia □ Cold Sores □ Grinding/Clenching □ List: □ Bleeding Problems □ ADD/ADHD □ Concussion □ Injury to Teeth/Jaws □ Tuberculosis □ Thyroid/Hormonal Imbalance □ Severe Headaches □ Diabetes □ Lip Biting □ Any TMJ History □ Convulsions/Scizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If So, who: If Female: Menstruating? Yes No Date of First Period: □ Shaving? Yes No Date Started: □ Shaving? Yes		<u> </u>		
□ Anemia □ Cold Sores □ Grinding/Clenching □ List: □ ADD/ADHD □ Concussion □ Injury to Teeth/Jaws □ Tuberculosis □ Thyroid/Hormonal Imbalance □ Severe Headaches □ Diabetes □ Lip Biting □ Pacial Pain □ Major □ Convulsions/Seizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: If Female: Menstruating? Yes No Date of First Period: □ / □ Shaving? Yes No Date Started: □ / □ Shaving? Yes No Date Start			_	
□ Bleeding Problems □ Ulcers □ Injury to Teeth/Jaws □ Injury to Teeth/Jaws □ Ulcers □ Injury to Teeth/Jaws □ Injury to				□ Other Allergy:
Gum Problems Ulcers Injury to Teeth/Jaws Universed to Thyroid/Hormonal Imbalance Severe Headaches Diabetes Ulip Biting Facial Pain Major Any TMJ History Nail Biting Nervous Disorder Immune Deficiency Presently Suck Thumb/Finger Hearing Problem Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: If Female: Menstruating? Yes No Date of First Period:/_ Shaving? Yes No Date Started:/_ Shaving? Yes No Date S			_	nching List:
□ Tuberculosis □ Thyroid/Hormonal Imbalance □ Severe Headaches □ Diabetes □ Lip Biting □ Facial Pain □ Major □ Convulsions/Seizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who:  If Female: Menstruating? Yes No Date of First Period:/  If Male: Voice Change? Yes No Date Started:/_/ Shaving? Yes No Date Started:/_/  Names of Daily Medications?  Is there any other information about the patient's health we should know?  Whom may we thank for the referring you to our office?  Please circle all that apply:  My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List  North Shore Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in:  My Friend/Relative Referred Me (list name(s)):  Other (please specify):				
□ Diabetes □ Lip Biting □ Facial Pain □ Major □ Repilepsy □ Nail Biting □ Any TMJ History □ Convulsions/Seizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: □ If Female: Menstruating? Yes No Date of First Period: □ /			5 5	
□ Epilepsy □ Nail Bitting □ Any TMJ History □ Convulsions/Seizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: If Female: Menstruating? Yes No Date of First Period: □/□/ If Male: Voice Change? Yes No Date Started: □/□/ Shaving? Yes No Date Started: □/□/ Shaving? Yes No Date Started: □/□/ Shaving? Yes No Date Started: □/□/ Whom may we thank for the referring you to our office? Please circle all that apply:  Whom may we thank for the referring you to our office? Please circle all that apply:  My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List North Shore Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in: □// My Friend/Relative Referred Me (list name(s)): □// Other (please specify): □// Other (ple	Tuberculosis	☐ Thyroid/Hormonal Imbalance	e □ Severe Heada	
□ Convulsions/Seizures □ Tongue Thrusting □ Nervous Disorder □ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: □ If Female: Menstruating? Yes No Date of First Period: □ / □ / □ Shaving? Yes No Date Started: □ / □ / □ / □ Shaving? Yes No Date Started: □ / □ / □ / □ Shaving? Yes No Date Started: □ / □ / □ / □ / □ / □ / □ / □ / □ / □	Diabetes	□ Lip Biting	□ Facial Pain	□ Major Surgery
□ Immune Deficiency □ Presently Suck Thumb/Finger □ Hearing Problem □ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: □ If Female: Menstruating? Yes No Date of First Period: □ / □ / □ If Male: Voice Change? Yes No Date Started: □ / □ / Shaving? Yes No Date Started: □ / □ / Names of Daily Medications? □ Is there any other information about the patient's health we should know? □ □ Whom may we thank for the referring you to our office? Please circle all that apply:  My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List North Shore Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in: □ My Friend/Relative Referred Me (list name(s)): □ Other (please specify): □ Other (please specify)	Epilepsy	□ Nail Biting	□ Any TMJ His	tory
□ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who:  If Female: Menstruating? Yes No Date of First Period:  If Female: Voice Change? Yes No Date Started:  If Male: Voice Change? Yes No Date Started:  If Male: Voice Change? Yes No Date Started:  Is there any other information about the patient's health we should know?  Whom may we thank for the referring you to our office?  Please circle all that apply:  My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List  North Shore Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in:  My Friend/Relative Referred Me (list name(s)):  Other (please specify):  Other (please specify):	Convulsions/Seizures	□ Tongue Thrusting	□ Nervous Diso	rder
□ Smoke Cigarettes/Cigars  Has Patient ever had orthodontic treatment or worn a retainer? Yes No Does anyone else in the family have a similar orthodontic problem? Yes No If so, who:  If Female: Menstruating? Yes No Date of First Period:  If Female: Voice Change? Yes No Date Started:  If Male: Voice Change? Yes No Date Started:  If Male: Voice Change? Yes No Date Started:  Is there any other information about the patient's health we should know?  Whom may we thank for the referring you to our office?  Please circle all that apply:  My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List  North Shore Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in:  My Friend/Relative Referred Me (list name(s)):  Other (please specify):  Other (please specify):	Immune Deficiency	□ Presently Suck Thumb/Fing	er   Hearing Probl	lem
Does anyone else in the family have a similar orthodontic problem? Yes No If so, who:  If Female: Menstruating? Yes No Date of First Period:/_/_  If Male: Voice Change? Yes No Date Started:/_/_ Shaving? Yes No Date Started:/_/  Names of Daily Medications?  Is there any other information about the patient's health we should know?  Whom may we thank for the referring you to our office?  Please circle all that apply:  My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List  North Shore Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in:  My Friend/Relative Referred Me (list name(s)):  Other (please specify):  Other (please specify):	Smoke Cigarettes/Cigars	-	_	
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Other (please specify):				
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				Date: / /