RYE FAMILY ORTHODONTICS

Leon Su, DDS, MS

105-107 Theodore Fremd Avenue, Rye, New York 10580 • Phone: 914-967-7648

Patient Information:

Date: ______________________________

Name: ______________________ Referred By: ______________________

Soc. Sec.#: ______________ Birthday: __________ Home Phone: ______________

Cell Phone: ______________ Email Address: ______________________

Address: ______________ City: __________ State: ________ Zip: ______

If Student, Name of School/College: ______________________

Patient's/Parent's Employer: ______________________ Work Phone: ______________

Business Address: ______________ City: __________ State: ________ Zip: ______

Spouse or Parent's Name ______________ Employer: ______________ Work Phone: ______________

Person to Contact in Case of Emergency: ______________________ Phone: ______________

Responsible Party:

Person responsible for the Account: ______________ Relationship: ______________

Address: ______________________ Phone: ______________

Employer: ______________ Work Phone: __________ SSN# ______________

Insurance Information:

Name of Insured: ______________________ Relationship: ______________

Birthdate: ______________ SSN#: ______________ Ins. ID#: ______________

Name of Employer: ______________________ Work Phone: ______________

Insurance Company: ______________ Group: __________ Ins. Co. Phone: ______________

Do You Have Any Additional Insurance? ______ If so, complete the following: ______________

Name of Insured: ______________________ Relationship: ______________

Birthdate: ______________ SSN#: ______________ Ins. ID#: ______________

Name of Employer: ______________________ Work Phone: ______________

Insurance Company: ______________ Group: __________ Ins. Co. Phone #: ______________

Name of Dentist ______________________ Date of Last Exam: ______________

Address: ______________________ Phone: ______________

What is your primary reason for seeking Orthodontic treatment? ______________________

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Patient Medical History

Physician:______________________ Office Phone:______________________ Date of Last Exam:__________

Pharmacy Name:______________________ Pharmacy Phone:______________________

		Yes	No
1.	Are you in good health at this time?	☐	☐
2.	Are you under medical treatment now?	☐	☐
	If yes, for what condition or treatment ______________	☐	☐
3.	Have you been, hospitalized in the last 5 years?	☐	☐
	If yes, please explain ______________		
4.	Are you taking any medication(s) including non-prescription, nutritional supplements and vitamins?	☐	☐
	If yes, please list: ______________		
5.	Do you use tobacco?	☐	☐
6.	When were you last treated by a physician ______________		
	For what condition?______________		

		Yes	No
8.	Are you allergic to or have you had any reactions to the following?		
	Local Anesthetics, (e.g. Novocaine)	☐	☐
	Penicillin or any other Anibiotics	☐	☐
	Sulfa Drugs	☐	☐
	Barbiturates	☐	☐
	Sedatives	☐	☐
	Codeine	☐	☐
	Iodine	☐	☐
	Aspirin	☐	☐
	Any Metals (e.g. nickel, mercury, etc.)	☐	☐
	Latex Rubber	☐	☐
	Other______________		
9.	Women Only		
	a) Are you pregnant or think you may be pregnant	☐	☐
	b) Are you nursing	☐	☐
	c) Are you taking oral contraceptives?	☐	☐
10.	Are you currently taking or have taken in the past Biophosphate medications such as Fosomax, Zometa or Aredia?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma, Shortness of breath	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions, Seizures	☐	☐
Leukemia	☐	☐
Diabetes, Dry Mouth, Excessive Urination	☐	☐
Kidney Diseases, Frequent Urination	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Emotional Problems (Mental Disease)	☐	☐
Heart Disease	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia, Thin or Low Blood Count	☐	☐
Emphysema	☐	☐
Cancer or Radiation Treatment	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Blood Transfusion	☐	☐
Excessive Bleeding, Hemophilia	☐	☐

	Yes	No
Duodenal or Stomach Ulcer	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke, or Numbness	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis, or lived w/ TB Patient	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble, Chest Pain	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Name and disorders that you ever had that are not mentioned above? ______________		

Patient Dental History

		Yes	No
1.	Have you had previous braces?	☐	☐
	If yes, by whom ______________		
2.	Do your gums bleed while brushing or flossing?	☐	☐
3.	Have you ever been treated for gum disease?	☐	☐
4.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
5.	Are your teeth sensitive to sweet, or sour liquids/foods?	☐	☐
6.	Do you feel pain in any of your teeth?	☐	☐
7.	Do you have any sores or lumps in or near your mouth?	☐	☐
8.	Have you had any head, neck or jaw injuries?	☐	☐
9.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	☐	☐
	Pain (front ear, side of face)	☐	☐
	Difficulty in opening or closing	☐	☐
	Difficulty in chewing	☐	☐

		Yes	No
10.	Do you have a bad taste in your mouth?	☐	☐
11.	Do you have frequent headaches?	☐	☐
12.	Do you clench or grind your teeth?	☐	☐
13.	Do you bite your lips or cheeks frequently?	☐	☐
14.	Have you ever had any difficult extractions in the past?	☐	☐
15.	Have you ever had any prolonged bleeding following extractions?	☐	☐
16.	Do you have any loose teeth	☐	☐
17.	Have any of your teeth shifted?	☐	☐
18.	Do you have any dental implants?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X______________________ Date__________

Signature of patient

Signature of Doctor ______________________