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Patient Information

Patient's Name: _____ Male Female

Date of Birth: ____/____/____ E-Mail Address: _____ Married Divorced Single
Marital Status

Address: _____
Street Town State Zip

How long at this address? _____ Home Phone: (____) _____ Work Phone: (____) _____

Previous Address (if less then 3 yrs.) _____

Social Security #: _____ Date of Birth: ____/____/____ Work Phone (____) _____
Street Town State Zip

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Relationship to Patient: _____
First Middle Last

Employer: _____ Occupation: _____ No. Years Employed: _____

Social Security #: _____ Date of Birth: ____/____/____ Work Phone: (____) _____

Dental Insurance Information

Primary Policy Holder: _____ Secondary Policy Holder: _____

SS# of Policy Holder: _____ SS# of Policy Holder: _____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's Date of Birth: ____/____/____

Insurance Company: _____ Insurance Company: _____

Insurance Address: _____ Insurance Address: _____

Insurance Group/Policy#: _____ Insurance Group/Policy#: _____

- I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to Island Orthodontics of the insurance benefits otherwise payable to me.
- I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
- I certify that the above information is complete and true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: ____/____/____



Patient's Medical/Dental History

Patient's Dentist: _____ Phone#: (____) _____ Last Visit: _____

What is patient's primary concern: _____

Patient's Physician: _____ Phone#: (____) _____ Last Visit: _____

Is patient presently being treated by a physician? Yes No Why?: _____

Has the patient's tonsils and adenoids been removed? Yes No

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?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Problems Opening/Closing | <input type="checkbox"/> Metal Allergy |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Chewing Problems | <input type="checkbox"/> Seasonal Allergy |
| <input type="checkbox"/> Pre Medication Required | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Jaw Popping | <input type="checkbox"/> Other Allergy:
List: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Grinding/Clenching | _____ |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Concussion | _____ |
| <input type="checkbox"/> Gum Problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Injury to Teeth/Jaws | _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid/Hormonal Imbalance | <input type="checkbox"/> Severe Headaches | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lip Biting | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Major Surgery |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Any TMJ History | _____ |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Tongue Thrusting | <input type="checkbox"/> Nervous Disorder | _____ |
| <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Presently Suck Thumb/Finger | <input type="checkbox"/> Hearing Problem | _____ |
| <input type="checkbox"/> 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: _____

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

Island Orthodontics Website Invisalign Website Yellow Page Ad Newspaper Ad in: _____

My Friend/Relative Referred Me (list name(s)): _____

Other (please specify): _____

Signature: _____ Date: ___/___/___

Review by Doctor: _____ Date: ___/___/___