Efraim Zak, D.D.S.

ISLAND ORTHODONTICS

Practice Limited to Orthodontics

1990 Deer Park Avenue
Deer Park, New York 11729
Phone: (631) 586-7654
www.IslandOrtho.COM

Patient Information

Patient's Name: _____ □ Male □ Female
First Middle Last

Date of Birth: ____/____/____

Address: _____
Street Town State Zip

If Patient is a minor, give parent's/guardian's name(s): _____

Names/Ages of brothers and sisters: _____

_____

Responsible Party Information

Name: _____ □ Married □ Divorced □ Single
First Middle Last Marital Status

Custodial Parent: □ Mother □ Father □ Both E-Mail Address: _____

Address: _____
Street Town State Zip

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

Previous Address (if less then 3 yrs.) _____
Street Town State Zip

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

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	Secondary
Policy Holder: _____	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 (Parent's if minor): _____ Date: ___/____/____

Over

Patient's Medical/Dental History

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

What is patient's/parent'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 Is child adopted? Yes No

Has the patient ever had an unusual reaction to any drug? Yes No Is child aware of adoption? 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	□ Asthma	□ Arthritis	□ Latex Allergy
□ Rheumatic Fever	□ Breathing Problems	□ Problems Opening/Closing	□ Metal Allergy
□ Mitral Valve Prolapse	□ Frequent Colds	□ Chewing Problems	□ Seasonal Allergy
□ Pre Medication Required	□ Sinus Problems	□ Jaw Popping	□ Other Allergy:
□ Anemia	□ Cold Sores	□ Grinding/Clenching	List: _____
□ Bleeding Problems	□ ADD/ADHD	□ Concussion	_____
□ Gum Problems	□ Ulcers	□ Injury to Teeth/Jaws	_____
□ Tuberculosis	□ Thyroid/Hormonal Imbalance	□ Severe Headaches	_____
□ Diabetes	□ Lip Biting	□ Facial Pain	□ Major Surgery
□ 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: ___/___/___

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

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

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

_____

Other (please specify): _____

_____

_____

Signature (Parent's if minor): _____ Date: ___/____/____

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