ALL ★ STAR
FAMILY ORTHODONTICS

Welcome to your Orthodontist!

3331 US Highway 9, Old Bridge, NJ 08857 (732) 727-6666

TELL US ABOUT YOURSELF

Today's Date: _____ ❑ Male ❑ Female

Name: _____

Birthdate: ____ / ____ / _____ Age: ____ SS#: _____

Address _____

_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: _____ Work #: _____ ext. _____

Mobile #: _____ Driver's Lic #: _____

E-mail address: _____

Employer: _____

Employer's Address: _____

_____

Occupation: _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

General Dentist: _____

General Dentist Address: _____

_____

Dentist's Phone: _____ Last Visit Date: _____

SPOUSE INFORMATION

Name: _____

Birthdate: ____ / ____ / _____ ❑ Male ❑ Female

Occupation: _____

Employer: _____

Employer's Address: _____

Work #: _____ ext. _____ SS#: _____

_____

In event of an emergency, is there somone who lives near you that we should contact?

Name: _____ Relation: _____

Home #: _____ Work/Mobile #: _____

ORTHODONTIC INSURANCE

Person Responsible for Account: _____

Relation: _____ Birthdate: ____ / ____ / _____

SS#: _____ Driver's Lic #: _____

Home Phone #: _____ Work #: _____ ext. _____

Mobile #: _____ Email: _____

Employer: _____

Employer's Address: _____

_____

PRIMARY

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone #: _____ Policy #: _____

Insured's Name: _____ Relation: _____

Birthdate: ____ / ____ / _____ SS#: _____

Insured's Employer: _____

Insured's Employer's Address: _____

_____

SECONDARY

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone #: _____ Policy #: _____

Insured's Name: _____ Relation: _____

Birthdate: ____ / ____ / _____ SS#: _____

Insured's Employer: _____

Insured's Employer's Address: _____

_____

MEDICAL HISTORY

Physician's Name: _____

Physician's Office #: _____ Date of last visit: _____

Continues on back

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I, hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

AUTHORIZATION

_____ _____

Signature of Patient or Guardian Date

MEDICAL HISTORY

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Are you taking any prescription or over the counter drugs? ❑ Yes ❑ No

Please List: _____

_____

FOR WOMEN ONLY

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If so, week#: _____

Are you nursing? ❑ Yes ❑ No

FOR EVERYONE:

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones/ Joints / Valves	Y	N	High/Low Blood Pressure
Y	N	Asthma / Arthritis	Y	N	HIV+/ AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for Any Reason
Y	N	Cancer/ Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug/ Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Severe/ Frequent Headaches
Y	N	Epilepsy / Seizures / Fainting	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Uclers/ Colitis
Y	N	Heart Surgery / Pacemaker	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics
Y	N	Penicillin	Y	N	Any Metals/ Plastics
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex
Y	N	Other:_____			

Please list any other drugs/ materials that you are allergic to:

_____

DENTAL HISTORY

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment: ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No Gums ever bleed? ❑ Yes ❑ No

Have you ever had an injury to your: ❑ Mouth ❑ Teeth ❑ Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes: ❑ While Awake? ❑ While Asleep?

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

Have you ever taken Phen-Fen?(Also known as Redux or Pondimin) ❑ Yes ❑ No

If yes, when? _____

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_____

SIGNATURE DATE

I authorize payment of dental benefits in accordance with my current insurance policy to All Star Family Orthodontics for professional services rendered. I understand that I am responsible for the payment and also responsible for any co-payment and deductibles that my insurance does not cover.

_____

SIGNATURE DATE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

SIGNATURE DATE

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: _____ Date: ____/_____/_____

Doctors Comments:

_____

_____

Although the initial consultation is complimentary, if records are required we will bill your insurance company. You will not be responsible for uncovered portion.

_____ _____

Signature Date