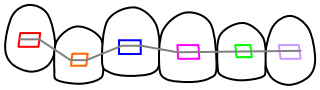
Northport Harbor Orthodontics
239 Main Street
Northport, New York 11768
631.754.1745



Village of the Branch Orthodontics
314 East Main Street
Smithtown, New York 11787
631.651.8580

Welcome to our office

Please fill out the following information as completely as possible. Indicate "N.A." for anything that is not applicable or "same" for duplicate responses. *Thank you.*

Patient's Information:

Name_____ Preferred Name_____
Birthdate_____ Preferred e-mail for letters_____ Preferred phone for contact _____
Who will be accompanying patient at appointments?_____
Whom may we thank for referring you to our office? _____

Parent / Guardian Information:

Father's Name_____
Birthdate_____ SSN_____
Home address_____

_____
City State Zip

Home phone_____ Cell Phone_____(May we text # Y N) E-mail_____
Occupation_____ Work Phone _____
Employer Name & Address_____

_____
City State Zip

Mother's Name _____
Birthdate_____ SSN_____
Home address_____

_____
City State Zip

Home phone_____ Cell Phone_____(May we text # Y N) E-mail_____
Occupation_____Work Phone _____
Employer Name & Address_____

_____
City State Zip

Billing Party Information

Who is responsible for this account?_____
Name Relationship to patient

Primary Insurance Information

Insurance Holder_____
Name Relationship to patient

Insurance Company Name_____
Insurance Company Address_____

_____
City State Zip

Insurance Company Phone_____
Claim Group #_____ SSN / ID #_____

Secondary Insurance: We do not accept assignment of benefits on secondary insurance. You are asked to pay for anything that your primary insurance does not cover.

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account and for any professional services rendered. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____
Name of Responsible Party Date

_____
Signature of Responsible Party

Medical History

Patient Name_____ Date of Birth_____
Name of Physician_____
_____
Address City State Zip Phone

Have you had any serious illnesses or operations? yes no If 'yes', please describe_____
_____

Please circle 'yes' or 'no':

AIDS/HIV	yes	no	Epilepsy	yes	no	Respiratory disease	yes	no
Anemia	yes	no	Fainting	yes	no	Rheumatic fever	yes	no
Arthritis	yes	no	Glaucoma	yes	no	Scarlet fever	yes	no
Artificial heart valves	yes	no	Headaches	yes	no	Shortness of breath	yes	no
Artificial joints	yes	no	Heart murmur	yes	no	Sinus troubles	yes	no
Asthma	yes	no	Hepatitis	yes	no	Skin rash	yes	no
Back problems	yes	no	Herpes	yes	no	Special diet	yes	no
Bleeding problems	yes	no	High blood pressure	yes	no	Stroke	yes	no
Blood disease	yes	no	Jaundice	yes	no	Swollen feet or ankles	yes	no
Cancer	yes	no	Jaw pain	yes	no	Swollen neck glands	yes	no
Chemical dependency	yes	no	Kidney disease	yes	no	Thyroid problems	yes	no
Chemotherapy	yes	no	Liver disease	yes	no	Tonsilitis	yes	no
Circulatory problems	yes	no	Low blood pressure	yes	no	Tuberculosis	yes	no
Congenital heart lesions	yes	no	Mitral valve prolapse	yes	no	Tumor on head or neck	yes	no
Cortisone treatments	yes	no	Nervous problems	yes	no	Ulcer	yes	no
Cough, persistent or bloody	yes	no	Pacemaker	yes	no	Venereal disease	yes	no
Diabetes	yes	no	Psychiatric care	yes	no	Weight loss, unexplained	yes	no
Emphysema	yes	no	Radiation treatment	yes	no			

Is there any other medical condition you have of which we should be aware?_____
_____
Are there any tactile or sensory issues or sensitivities of which we should be aware? Y N If yes, please explain ___ _____
List any medications you are taking and the correlating diagnosis_____
_____
Do you have any allergies? yes no If 'yes', please list_____
_____
Women: Are you pregnant?_____ Are you nursing?_____

Dental History

Reason for today's visit_____
Name of Dentist_____
_____
Address City State Zip Phone

Date of last dental visit_____ Date of last dental x-rays_____

Please circle 'yes' or 'no':

Bleeding gums	yes	no	Loose teeth	yes	no
Blisters on mouth or lips	yes	no	Previous history of orthodontic treatment	yes	no
Burning sensation on tongue	yes	no	Previous history of periodontal treatment	yes	no
Cigarette, pipe, or cigar smoking	yes	no	Sensitivity to cold	yes	no
If 'yes': How much/day _____			Sensitivity to heat	yes	no
How many years_____			Sensitivity to sweets	yes	no
Do you grind your teeth	yes	no	Sensitivity to biting	yes	no
Dry mouth	yes	no	Sores or growths in mouth	yes	no
Food collection between teeth	yes	no	How often do you brush?_____		
Swollen or painful gums	yes	no	How often do you floss?_____		
Jaw pain, clicking or popping	yes	no	History of Speech Therapy	yes	no

I certify that the above information is correct to the best of my knowledge.

Signed (parent, if minor)_____ Date_____