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New Patient Information

Thank you for choosing Dr. Levin's office, where we are committed to providing you with personalized service and care beyond your expectations. At your first visit you will receive a comprehensive, complimentary evaluation of your orthodontic concerns.

This questionnaire is crucial to the information gathering process, and your answers may impact Dr. Levin's diagnosis and treatment recommendations. Please complete this questionnaire and bring it with you to your appointment. We look forward to meeting you!

Patient's Last Name _____	First Name _____	MI _____	Preferred Name _____
Mailing address (Street and Unit) _____			
City _____	State _____	Zip _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone _____	DOB (mm/dd/yy) _____	Age _____	
How did you hear about us? Who may we thank for referring you to our office? Please specify _____			
Preferred method to receive appointment confirmations?			
<input type="checkbox"/> Text Cell # _____ <input type="checkbox"/> Email _____ <input type="checkbox"/> Both Text & Email			

PARENTS'/LEGAL GUARDIAN INFORMATION			
Mother's Full Name (with Title) _____	Mother's DOB (mm/dd/yy) _____		
Mailing address (if different than above) _____			
Cell Phone #1 _____	Work Phone #1 _____	OK to contact at work? <input type="checkbox"/> Y <input type="checkbox"/> N	
Father's Full Name (with Title) _____	Father's DOB (mm/dd/yy) _____		
Mailing address (if different than above) _____			
Cell Phone #2 _____	Work Phone #2 _____	OK to contact at work? <input type="checkbox"/> Y <input type="checkbox"/> N	
Mom's email _____	Dad's email _____		
Marital Status (parents') <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Patient lives with <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Who will primarily be responsible for bringing the patient to his/her orthodontic appts?			
Other (specify): _____ Please also indicate relationship to patient. _____			

WHO WILL BE SIGNING TREATMENT AND FINANCIAL CONSENT FORMS FOR THIS PATIENT?			
This person should be present at the initial evaluation and will be signing this form as well as any future financial forms			
First and Last Name (with Title) _____	Relation to patient _____		
Driver's License # _____	State issued _____	DOB (mm/dd/yy) _____	
Street Address, City, State, Zip (if different than patient's) _____			
< 3 yrs at this address? <input type="checkbox"/> Y <input type="checkbox"/> N	Best Contact Phone _____	Email address _____	
Occupation _____	Current Employer _____	Yrs with Current Employer _____	

If we will be submitting insurance forms on your behalf, or you would like insurance forms filled out for you so that you can file claims with your insurance company, please fill out this section:

INSURANCE INFORMATION			
Primary policy holder's full name _____	Relation to patient _____	DOB (mm/dd/yy) _____	
Dental Insurance Carrier Name _____	Employer _____		
Group # _____	ID # / SSN _____	Orthodontic benefit? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	
Insurance Carrier Address, City, State, Zip _____			
Insurance Phone _____	Insurance Fax _____		
Secondary policy holder's full name _____	Relation to patient _____	DOB (mm/dd/yy) _____	
Dental Insurance Carrier Name _____	Employer _____		
Group # _____	ID # / SSN _____	Orthodontic benefit? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	
Insurance Carrier Address, City, State, Zip _____			
Insurance Phone _____	Insurance Fax _____		

Your answers are for office records only, and are completely **confidential**. A thorough medical history is essential to a complete orthodontic evaluation. Please mark **yes, no, or don't know/understand (dk/u)**, when asked.

MEDICAL HISTORY

- yes no dk/u Is the patient in good general health? Date of last medical check-up or visit to a physician: _____
Reason for this visit: _____
- yes no dk/u Has there been any change to general health in the past year?
- yes no dk/u Is there currently treatment ongoing for any chronic medical condition or has treatment been provided for any medical condition within the past year? Please provide reason: _____
- yes no dk/u Is there a history of serious illness, hospitalization, or operations within the past five years?
Please specify: _____
- yes no dk/u Is there currently a need for medications (includes birth control) or non-prescription drugs/supplements of any kind?
Attach additional paper, if necessary.
Medication: _____ Dose: _____ Taken for: _____
Medication: _____ Dose: _____ Taken for: _____
Medication: _____ Dose: _____ Taken for: _____
- yes no dk/u Has your child ever taken any medication to strengthen bones (e.g., Fosamax, Actonel, Boniva)?
If yes, for how long (# Yrs)? _____ oral I.V.
- yes no dk/u Does your child currently chew or smoke tobacco? If yes, amount daily: _____ # Yrs: _____
- yes no dk/u Is there a history of any allergies *OR* any peculiar/adverse reactions to any medications or injections? Check all that apply:
 Local anesthesia "dental freezing" (e.g., novocaine, lidocaine, xylocaine)? Codeine or other narcotic Aspirin
 Ibuprofen (Motrin, Advil) Penicillin Other antibiotic (including sulfa drugs - Which? _____
 Latex (gloves, balloons) Metals (jewelry, clothing snaps) Plastics
 Seasonal or environmental (includes food)? Please specify: _____
Other allergies? _____
If yes, type of reaction experienced: _____

Allergy Alert: Y / N

Now or in the past, has your child had:

- | | |
|---|--|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Arthritis or joint problems? * | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Chest pain, shortness of breath, tire easily, swollen ankles? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Diagnosis of osteoporosis/osteopenia? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Heart defect, heart murmur, rheumatic heart disease, heart valve replacement? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Orthopedic total joint replacement? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Angina, arteriosclerosis, stroke or heart attack? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any injury to the face, head, neck? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Excessive bleeding, bruising, or anemia? * |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Diabetes or low blood sugar? * | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u High or low blood pressure? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Thyroid or other endocrine problem? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Polio, mononucleosis, tuberculosis, pneumonia? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Stomach ulcer, hyperacidity, acid reflux? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Bronchitis or emphysema? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Hepatitis (type?), jaundice or other liver problem? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Asthma, sinus problems, hay fever? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Kidney problem? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Frequent ear infections, colds, throat infections? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Cancer, tumor, radiation therapy or chemotherapy? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Tonsils and/or adenoids removed? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u AIDS or HIV positive? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Breathing through mouth or snoring at night? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Vision, hearing, or speech problem? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Excessive fatigue or trouble staying focused? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Seizures, fainting spells, neurologic problem? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u A diagnosis of sleep apnea? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Frequent headaches, neck aches, or migraines? | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Mental health struggle, to include anxiety or depression? | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Drug or alcohol dependency? | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u For girls only – are you pregnant? And if so, what is the expected delivery date? _____ | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u History of any other medical or emotional problems not listed?
Please describe: _____ | |

Medical Alert: Y / N

Pre-med Alert: Y / N

DENTAL HISTORY

yes no dk/u Is there a Family Dentist? Name: _____
Address and/or Tel no: _____
Date of last visit: _____ X-rays taken? Yes No Unsure
Reason for this visit: _____

yes no dk/u Are visits to the Dentist fairly regular (i.e., every 4 to 6 months)?
yes no dk/u Does your child brush and floss his/her teeth routinely?
Brushes teeth: ____ x /day Flosses teeth: ____ x /day or ____ x /week

Now or in the past, has your child had:

<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Primary (baby) teeth removed that were not loose?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Premedication with antibiotics regularly before certain dental procedures?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Permanent (adult) or "extra" teeth removed?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Tooth grinding or jaw clenching?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Chipped or otherwise injured teeth?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any pain, clicking or locking in jaw?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any wisdom tooth problems?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Difficulty in chewing, jaw opening, or ringing in ears?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Teeth sensitive to hot or cold; teeth throb or ache?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Pain or soreness in the muscles of the face or around the ears?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any loose, broken or missing fillings (now)?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Treatment for "TMD" or "TMJ" problems?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any sores, lumps, or irritations (now)?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Treatment by any other dental specialist?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Bleeding gums, bad taste or mouth odor?	Name: _____
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Periodontal "gum" problems or treatment?	Date: _____
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Frequent canker sores or cold sores (circle which)?	Reason: _____
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any fluoride supplementation?	
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Anything else regarding your child's past dental history not listed? Please describe: _____	

TMJ Alert: Y / N

ORTHODONTIC AND GROWTH HISTORY

yes no dk/u Is/are the orthodontic problems obvious to your child?
yes no dk/u Is your child sensitive or self-conscious about the appearance of his/her teeth or face?
yes no dk/u Has your child had any previous orthodontic treatment?
yes no dk/u Is there history of or ongoing frequent oral habit? Check all that apply:
 Thumb/finger sucking Lip biting Nail biting Tongue thrusting Speech Other
Comments: _____

yes no dk/u Has your child started to grow quickly? Patient's current ht: ____ ft ____ in.
Birth mother's ht: ____ ft ____ in. Birth father's ht: ____ ft ____ in.

yes no dk/u Has your child seemed to stop growing for the last few months?
yes no dk/u For girls only - Has your child started her monthly period? If yes, at what age? _____
yes no dk/u For boys only - Has your child's voice changed or has he started to shave? If yes, at what age? _____

Habit Alert: Y / N

Additional Growth:
 Y / N / Poss
 Family hx Cl III

Any specific concerns your child has about his/her teeth? _____
What concerns you about your child's teeth? _____
What concerns your family/pediatric dentist about your child's teeth? _____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in completing this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of Parent/legal guardian: _____ Date Signed: _____
Signature of TC who reviewed this form: _____ Date Signed: _____
Signature of the Doctor who reviewed this form: _____ Date Signed: _____

INSURANCE AUTHORIZATION (Needs to be signed if you would like us to submit your insurance claims on your behalf. If you would like to send your own claims to your insurance company, please leave this blank.)

To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signature of Parent/legal guardian: _____ Date Signed: _____

Patient's First Name: _____