Welcome to Park Slope Orthodontics

and congratulations on taking the first step to a new & healthy smile! Please take a moment to tell us about yourself, we look forward to meeting you!

* Required

Patient Information

*Name(First Last): _____*Birthdate:_____/_____/_____

Soc. Sec #:_____-_____-_____ *Age:_____ *Sex: M_____ F_____

*Address:_____

*City: _____ *State:_____ *Zip: _____

*E Mail:_____

Home # _____-_____-_____ Work # _____-_____-_____

*Cell # _____-_____-_____ Marital Status: _____

Patient' hobbies:_____

Appointment confirmations are sent by email and text message from our office by default:

Check all that apply to opt out of receiving confirmations: ☐ Email ☐Text Message

*Who may we thank for referring you to our office?_____

*What concerns you most about your teeth?_____

Responsible Party (If someone other than patient or if patient under 18 years of age)

*Name (First Last): _____Birthdate:_____/_____/_____

Soc. Sec #:_____-_____-_____ Age:_____ Sex: M_____ F_____

Address: _____

City: _____ State:_____ Zip: _____

E Mail: _____

Home # _____-_____-_____ Work # _____-_____-_____

Cell # _____-_____-_____ Marital Status: _____

Dental Insurance Information (Please do not list medical insurance)

Primary Insurance Name:_____

Primary Holder: _____

Primary Holder Birthdate:_____/_____/_____ Relation: _____

Primary Holder ID/SSN: _____/_____/_____

Secondary Insurance Information

Secondary Insurance Name: _____

Secondary Holder: _____

Secondary Holder Birthdate:_____/_____/_____ Relation: _____

Secondary Holder ID/SSN: _____/_____/_____

Dental history

Former or current dentist's name: _____Phone(_____)_____

Date of last dental care: _____ Date of last dental x-ray: _____

Has the patient ever had any of the following dental concerns? (Check all that apply)

☐ Has patient ever sucked thumb or fingers?	☐ Any noticeable difficulty in chewing or swallowing food?	☐ Does anyone in family have similar dental condition?
☐ Does the patient clench or grind teeth(at night)?	☐ Does the patient breathe predominantly through the mouth?	☐ Does the patient have any speech problems?
☐ Have any teeth been chipped due to accidents?	☐ Does the patient have pain or clicking upon closing the mouth?	☐ Has the patient had any severe head or face injuries?
☐ Were any teeth (baby or permanent) removed by extraction?	☐ Have you been informed of missing permanent teeth?	☐ Have you been informed of any extra teeth?
☐ Have you ever had any previous orthodontic consultation or treatment?	☐ Was it suggested that the space be maintained?	☐ Was an appliance placed to maintain the space would patient mind wearing "braces"?

Is there anything else you would like to tell us that we haven't already asked?

_____

Is there anything we can do to make your visit more comfortable?_____

Medical history

Physician's name:_____Phone(_____)_____

Date of last visit_____

For Women: Pregnant ☐ Y ☐N Nursing ☐ Y ☐N Taking birth control pills? ☐ Y ☐N

Has the patient ever had any of the following medical concerns? (check all that apply)

☐ – AIDS/HIV Positive ☐ – Anaphylaxis ☐ – Anemia ☐ – Arthritis ☐ – Rheumatism ☐ – Artificial heart valve ☐ – Artificial joints ☐ – Asthma ☐ – Atopic (allergy prone) ☐ – Back problems ☐ – Blood disease ☐ – Cancer ☐ – Chemical dependency ☐ – Chemotherapy ☐ – Circulatory problems ☐ – Cortisone treatments ☐ – Cough, persistent ☐ – Cough up blood ☐ – Diabetes ☐ – Epilepsy ☐ – Fainting	☐ – Food allergies ☐ – Glaucoma ☐ – Headaches ☐ – Heart murmur ☐ – heart problems _____ ☐ – Hemophilia / Abnormal bleeding ☐ – Herpes ☐ – Hepatitis ☐ – High blood pressure ☐ – Jaw pain ☐ – Kidney disease or malfunction ☐ – Liver disease ☐ – Material allergies (**latex**; wool; metal; chemicals) ☐ – Mitral valve prolapse ☐ – Nervous problems ☐ – Pacemaker / heart surgery ☐ – Psychiatric care ☐ – Rapid weight gain or loss ☐ – Radiation treatment	☐ – Respiratory disease ☐ – Rheumatic ☐ – Scarlet fever ☐ – Shingles ☐ – Shortness of breath ☐ – Skin rash ☐ – Spina Bifida ☐ – Stroke ☐ – Surgical implant ☐ –swelling of feet or ankles ☐ – Thyroid disease or malfunction ☐ – Tobacco habit ☐ – Tonsillitis ☐ – Tuberculosis ☐ – Ulcer / Colitis ☐ – Venereal disease

Is the patient currently taking any medications? ☐ Y ☐N If yes, please list all_____

Does the patient have drug allergies? If yes, list all _____

Emergency Contact Information

*Emergency contact's name (First Last Name)_____

*Emergency contact's relationship to patient:_____

*Emergency contact's phone #_____-_____-_____

Park Slope Orthodontics

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

*Patient's Name

_____

*Signature

_____Date_____

*Relationship to Patient

_____

Orthodontic Appointment & Cancelation Policy

At Park Slope Orthodontics, our goal is to provide quality orthodontic care in a timely manner. We have implemented an appointment/cancelation policy which enables us to better utilize available appointments for our patients in need of care.

Cancelation of Appointment

Please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment.

If it is necessary to cancel your scheduled office appointment we require that you give at least 24 hours notice. Because of the necessary supplies and equipment allotted for treatment procedures, any cancellation not made prior to the 24 hours will be subject to a fee of $80.00. This fee will not be billed to insurance. (Exceptions can be made in case of family/medical emergencies)

Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely orthodontic care.

How to cancel your appointment: To cancel appointment call the Office at 718-399-3210

No Show Policy

A ”no show” is someone who misses an appointment without canceling it by 9AM. One (1) working day in advance. No-shows inconvenience those individuals who need access to care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients’ chart as a ‘no show’ and can as well be subject to a fee of $80.00 or suspension of service.

Patient Name: _____ Date:_____

Patient Signature:_____