STONY BROOK ORTHODONTICS

Patient Information: Today's Date: _____

Patient's Last/First Name:_____ _____ D.O.B _____

Parent/Guardian's Name: _____

Full Mailing
Address:_____

Preferred Phone number :_____(cell or Home) Alternate number:_____

Email address (optional): _____

In case of Emergency who should we contact: Name/phone #_____

Whom can we thank for referring you to our office?_____

Dental Information:

Is this your first orthodontic consultation? Yes No

Have you had any prior orthodontic treatment? Yes No

Who is your current dentist? _____

What is your dentist's phone number: _____

When was your last dental checkup and cleaning? 3 mo 6mo 1 yr 2yr >2 yrs

Have you ever suffered trauma to any of your teeth or jaw? Yes No

Do you experience frequent jaw pain, clicking of your jaw or headaches: Yes No

How many times a day do you brush your teeth _____

Do You Floss regularly? Yes No

2500 Nesconset Hwy, Building 4, Ste B, Stony Brook, NY 11790
(631) 675-2700

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Medical Information:

Are you in good health? **Yes** **No**
Are you currently under the care of a physician? **Yes** **No**
Physician's Name and phone number:_____
List Current Medication: _____
List any Allergies to medication:_____
Are you allergic to any antibiotics or aspirin? Please explain_____
Have you had been hospitalized in past 5 years? **Yes** **No** Please explain:_____
Do you use tobacco products**:** **Yes** **No**
Are you pregnant? **Yes** **No**
Have you ever been diagnoses with any of the following:

Damaged/ artificial Heart Valve?	Y	N		Y	N
Heart murmur			Tuberculosis (TB)		
Rheumatic Heart Disease			Fainting spells or seizures		
Cardiovascular disease			Autoimmune Disease		
High/Low blood pressure			HIV		
Stroke			Liver Disease/Hepatitis		
Cardiac pacemaker			Thyroid Disease		
Do your ankles swell			Depression		
Frequent Sinus infections			Major surgery		
Asthma			Arthritis/Rheumatic Disease		
GI Disease			Vertigo		
Endocrine Disorder			Persistent cough		
Kidney Disease			Problems with mental health		
Diabetes			anemia		
Cancer, or tumor			Tempromandibular Dysfunction		
taken bisphosphonates			History of Eating Disorder		

Is there any other medical or dental condition that was not asked that you feel is important for us to know about: _____

I have read and understood the above questions. I agree not to hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any medical or dental changes, or if your address or phone number change please remember to let us know.

Signature of Patient: _____ Date Signed: _____

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Signature of Parent/Guardian: _____ Date Signed: _____

Signature of Dental Staff: _____

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