Kozlowski Orthodontics, P.C.

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www.kozbraces.com

Confidential Patient Information

Patient's Name____ Sex: M F
Last First Middle

Address____
Street City State Zip

Home Phone_________________________ Birthdate______________________________

Who is your dentist?____________________ When was your last appointment?______________

Whom may we thank for referring you to our office?_______________________________

Have any family members had orthodontic treatment? ____________________________________

Confidential Responsible Party Information

Name ____ Marital Status S M D W
Last First Middle

Residence ____
Street City State Zip

Mailing Address____
Street City State Zip

How long at this address _________ Previous City/State (if less than 3 yrs.)______________

Would you like to receive appointment reminders via email or be able to access account info on line? □ *Yes* □ *No*

Primary Email Address: _______________________________________

Home Phone ________________ Work Phone ________________ Cell Phone_____________

Social Security #_______________ Birthdate _______________ Relationship to Patient ______

Employer_________________________ Occupation____________ No. Years Employed _____

Spouse's Name____ Relationship to Patient ______
Last First Middle

Employer_________________________ Occupation____________ No. Years Employed _____

SSN# ___________ Birthdate ________ Work Phone____________Cell Phone_____________

Dental/Orthodontic Insurance Information

Policy Holder's Name________________________________ and Soc.Sec. #_______________

Policy Holder's Date of Birth: _________________Member ID Number: _________________

Insurance Company_________________________ Group No.________ Union Local No.__________

Insurance Co. Address________________________________ Insurance Co. Phone____________

Policy Holder's Employer____

Do you have dual coverage? No ☐ Yes ☐ *If yes, please complete below:*

Policy Holder's Name________________________________ and Soc. Sec. #_______________

Policy Holder's Date of Birth: ___________________Member ID Number: __________________

Insurance Company_________________________ Group No.________ Union Local No.__________

Insurance Co. Address________________________________ Insurance Co. Phone____________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)___________________________ Date____________

Emergency Information

Name of nearest relative not living with you____

Complete Address____

Phone___________________________ Relationship:___________________________________

Confidential Medical and Dental History

Have you ever had any of the following medical problems?

Y N Abnormal bleeding
Y N Allergies to any drugs
Y N Allergy to latex
Y N Any hospital stays
Y N Any operations/surgery
Y N Asthma
Y N Cancer
Y N Chronic sinus problems
Y N Congenital heart defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Endocrine/Growth disorders
Y N Handicaps/Disabilities
Y N Hearing impairment
Y N Heart murmur
Y N Hemophilia/Blood disorders
Y N Hepatitis
Y N HIV/AIDS
Y N Kidney/Liver problems
Y N Nickel allergy
Y N Rheumatic/scarlet fever
Y N Tonsils/adenoids removed
Y N Tuberculosis
Other_____________________

Have you ever been told to take an antibiotic prior to dental visits? Y N
Are you currently under the care of a physician for any medical problems? Y N
Are you currently or have you ever taken Bisphosphonate drugs (Fosamax, Actonel, Boniva)? Y N
Please discuss any ***yes*** answers in the space provided: ____
____
____

Please describe your current physical health: Good Fair Poor
When was your last physical? _________________________ Your Physician: ___________________________
Please list any drugs/medications that you are currently taking: ____________________________________
____

Does you have any of the following habits?

Y N Clenching or grinding teeth
Y N Mouth breathing
Y N Nail biting
Y N Speech problems and/or speech therapy
Y N Tongue thrust
Y N Smoking

What are the main concerns that you would like orthodontic treatment to address? ___________________
____
____

Have you ever been evaluated or had orthodontic treatment before? Y N
Have you ever received an injury to the face, mouth, teeth, or chin? Y N
Have you been informed about any missing or extra permanent teeth? Y N
Have you ever had any pain, tenderness, and/or clicking in the temporomandibular joint (TMJ)? Y N
Please discuss ***yes*** answers to the above questions: ____
____
____

Do you have good oral hygiene habits? Y N
Do you see a general dentist regularly for check-ups? Y N
Do you have any pending restorative treatment planned with your dentist? Y N
Please make any other comments that you feel may be helpful____
____
____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status.

____________________________________ ____________________________________
Signature of Parent or Guardian Date

8.13.08