



northcut orthodontics

PETER A. SHAPIRO, DDS MSD PS

ORTHODONTICS FOR ALL AGES

PATIENT INFORMATION

DATE

LAST NAME		FIRST NAME		NICKNAME		SOC. SEC.#		SEX	BIRTH DATE	AGE
MAILING ADDRESS				CITY			STATE	ZIP	HOME PHONE	
SCHOOL		GRADE	<input type="checkbox"/> SINGLE	<input type="checkbox"/> SEPARATED	EMPLOYED BY / OCCUPATION			BUSINESS PHONE		
<input type="checkbox"/> MARRIED			<input type="checkbox"/> DIVORCED							
WHOM MAY WE THANK FOR RECOMMENDING US?				NAME OF DENTIST			DATE OF LAST VISIT			
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE										

PATIENT INFORMATION (please complete if patient is a minor)

FATHER'S NAME: _____			MOTHER'S NAME: _____		
ADDRESS (if different than patient's): _____			ADDRESS (if different than patient's): _____		
CITY: _____ ST: _____ ZIP: _____			CITY: _____ ST: _____ ZIP: _____		
HOME PHONE: _____ WORK PHONE: _____			HOME PHONE: _____ WORK PHONE: _____		
EMPLOYER: _____			EMPLOYER: _____		
EMPLOYER ADDRESS: _____			EMPLOYER ADDRESS: _____		
CITY: _____ ST: _____ ZIP: _____			CITY: _____ ST: _____ ZIP: _____		

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME		RELATIONSHIP TO PATIENT			EMPLOYED BY / OCCUPATION			
MAILING ADDRESS				CITY		STATE	ZIP	HOME PHONE
CELL PHONE	BUSINESS PHONE		SOC. SEC.#		E-MAIL ADDRESS			
IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?			MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					

INSURANCE INFORMATION

PRIMARY INSURED'S NAME: _____		SOC. SEC.# _____	
INSURANCE COMPANY NAME: _____		GROUP# _____	
INSURANCE COMPANY ADDRESS: _____			
DO YOU HAVE DUAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
2ND INSURED'S NAME: _____		SOC. SEC.# _____	
INSURANCE COMPANY NAME: _____		GROUP# _____	
INSURANCE COMPANY ADDRESS: _____			

EMERGENCY INFORMATION

CONTACT PERSON IN CASE OF EMERGENCY: _____	
PHONE # _____	RELATIONSHIP: _____



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MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____

Is your child currently experiencing health problems? YES NO Explain: _____

Is your child currently taking medications? YES NO List: _____

Is your child allergic to any medications? YES NO List: _____

Have your child's tonsils or adenoids been removed? YES NO

Please check if your child has had any of the following conditions:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Emotional Disorder	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Growth Disorders	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mouth Breathing	<input type="checkbox"/> Developmental Disorder	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Allergies
<input type="checkbox"/> Fainting				

Is there any other condition or problem that you think we should know about? _____

INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Does your son or daughter have (had) a finger sucking habit? YES NO

Has your son or daughter reached puberty? YES NO

Girls: started menstruation? YES NO When: _____ Boys: voice changed? YES NO When: _____

Height _____ Do you feel growth is completed? YES NO

Father's height _____ Mother's height _____ Adopted? YES NO

DENTAL HISTORY

Is there any unfinished dental care? YES NO

Is your child apprehensive about dental treatment? YES NO

Has your child had previous orthodontic treatment? YES NO With whom: _____

Have siblings or parents had orthodontic treatment? YES NO

Please check if there is a history of:

<input type="checkbox"/> Clenching	<input type="checkbox"/> Muscular Soreness Around Head and Neck	<input type="checkbox"/> Jaw Joint Soreness
<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Headaches	<input type="checkbox"/> Jaw Joint Popping/Clicking
<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Speech Problems	

Is there any other information that may be helpful? _____

I understand that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence per HIPPA regulations. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Parent Signature _____ Date _____

Health History Review: _____
