237 EVERETT AVENUE | WYCKOFF NJ 07481 | 201.891.5534 | MARTIN-ORTHO.COM

Welcome to Martin Orthodontics.
We'll need some information about you.

GRAY AREA FOR OFFICE USE

Account # ______

NOTES:

Today's date: ______

Patient's name: ______

Street address: ______

City/State/ZIP: ______

Email address: ______

Date of birth: ______ Current age: ______ Male ☐ Female ☐

Marital status: ______

Emergency contact: ______

Person responsible for payment: ______

Relationship to patient: ______

School: ______

Grade: ______

Home phone: ______

Cell phone: ______

Work phone: ______

Emergency phone: ______

Responsible party's address: ______
IF DIFFERENT FROM ABOVE

DENTAL INSURANCE INFORMATION:

Primary insurance company: ______

Policy holder's name: ______

Date of birth of policy holder: ______

Insurance company address: ______

______

______

Insurance company telephone: ______

Policy#: ______ Group #: ______

Secondary insurance company: ______

Subscriber's name: ______

Date of birth of policy holder: ______

Insurance company address: ______

______

______

Insurance company telephone: ______

Policy#: ______ Group #: ______

GRAY AREA FOR OFFICE USE

REFERRAL INFORMATION:

If you were referred by a Martin Orthodontics patient, please tell us who: ______

If you were referred by a dentist, please tell us who: ______

HEALTH INFORMATION:

Your regular dentist: ______________________ Telephone: ______________________

Regular dentist's address: ______________________ City/State/ZIP: ______________________

Date of your last dental visit: ______________________

Has any other **orthodontist** been consulted relative to your case? Yes ☐ No ☐

If you answered "yes" above, name of orthodontist? ______________________

Please answer the following questions by putting a check mark next to the appropriate answer. Check ALL that apply.

ARE YOU ALLERGIC TO LATEX?	Yes	No
Do you ever grind or clench your teeth?	Yes	No
Does your jaw "click" or "pop" or "lock" upon opening or closing?	Yes	No
Have you ever experienced pain in or around the ear?	Yes	No
Have you ever suffered trauma to the front teeth?	Yes	No
Any previous major illnesses or hospitalizations?	Yes	No
If yes, please describe:		
ANY ALLERGIES TO MEDICINES OR METALS?	Yes	No
If yes, please describe:		
CURRENTLY TAKING ANY MEDICATIONS?	Yes	No
If yes, please list/describe:		

Do you now or have you ever had any of the following diseases/conditions?
Please answer by putting a check mark next to the appropriate answer. Check ALL that apply.

Anemia	Yes	No
Asthma	Yes	No
AIDS/HIV	Yes	No
Abnormal Blood Pressure	Yes	No
Blood Disorders or Hemophelia	Yes	No
Cancer of any kind	Yes	No
Cold Sores	Yes	No
Diabetes	Yes	No
Epilepsy/Seizures	Yes	No
Headaches/Migraines	Yes	No

Heart Disease	Yes	No
Heart Murmur	Yes	No
Heart Valve Problems	Yes	No
Hepatitis	Yes	No
Herpes	Yes	No
Hives	Yes	No
Kidney Problems	Yes	No
Pneumonia	Yes	No
Rheumatic Fever	Yes	No
Tuberculosis	Yes	No

Signature (if you're a minor, please have your parent or guardian sign.)

____
SIGNATURE AND DATE

MARTIN ORTHODONTICS RESPECTS YOUR PRIVACY. Your responses will be kept in the strictest of confidence, and only disclosed for your treatment and/or payment purposes. If you would like a copy of our Privacy Policy, simply ask.