martin ORTHODONTICS 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: __________

Social security #: ____________________

Home phone: ____________________

Cell phone: ____________________

Work phone: ____________________

Emergency phone: ____________________

Responsible party's address: ____________________
IF DIFFERENT FROM ABOVE

INSURANCE INFORMATION:

Primary insurance company: ____________________

Policy holder's name: ____________________

Social security number on policy: ____________________

Policy#: __________ Group #: __________

Employer: ____________________

Date of birth of policy holder: ____________________

Patient's relationship to policy holder: ____________________

Secondary insurance company: ____________________

Subscriber's name: ____________________

Social security number on policy: ____________________

Policy#: __________ Group #: __________

Employer: ____________________

Date of birth of policy holder: ____________________

Patient's relationship to policy holder: ____________________

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: ____________________

martin
ORTHODONTICS

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.