Stephen M. Ossen, D.M.D.
Practice Limited To Orthodontics
584 Broadway, Hastings, NY 10706
914-478-0047

New Patient Information Form

Name of Patient: _____ Date of Birth: _____

Address: _____

Phone: _____School: _____ Grade: _____

Parents/Guardians

Name: _____

Address: _____

Business/Cell: _____

Occupation(optional): _____

Relationship to patient
( )biological parent ( )step ( )adoptive

Had orthodontic treatment ( )yes ( )no

Name: _____

Address: _____

Business/Cell: _____

Occupation(optional): _____

Relationship to patient
( )biological parent ( )step ( )adoptive

Had orthodontic treatment ( )yes ( )no

Contact email address _____

Dental Insurance Information

Primary Ins. Carrier
Subscriber: _____

SS #: _____ _____

Ins. Name: _____

Ins. Address: _____

Ins. Phone #: _____

Flex Spending acct. ( )yes ( )no

Secondary Ins. Carrier
Subscriber: _____

SS #: _____

Ins. Name: _____

Ins. Address: _____

Ins. Phone #: _____

Flex Spending acct. ( )yes ( )no

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

Name of dentist: _____ Date of last visit: _____

Has any other orthodontist been consulted regarding this patient? _____

Has the patient ever sucked his/her thumb or fingers?	( )yes	( )no
Has there ever been a history of trauma to the front teeth?	( )yes	( )no
Does he/she ever complain about pain in or around the ear?	( )yes	( )no
Does his/her jaw ever “pop or lock” upon opening or closing?	( )yes	( )no

(please turn over)

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MEDICAL QUESTIONAIRE

Patient's physician_____

Physician's address_____ Phone_____

Previous major illnesses or hospitalizations_____

_____

Does patient have any allergies, especially to metals or medications? If so, please list

_____

Is patient currently taking any medications?_____

_____
If female, is patient currently pregnant? Yes ( ) No ( )

Does the patient currently have, or has had in the past, any of the following:

	Yes	No
Asthma		
Anemia		
AIDS		
Abnormal blood pressure		
Blood disorders/hemophilia		
Cancer of any kind		
Cold Sores		
Diabetes		
Epilepsy/seizures		
Migraine Headaches		
Heart disease/heart murmur		
Heart murmur		
Rheumatic fever		
Herpes		
Hepatitis		
Hives		
Pneumonia		
Tuberculosis		
Kidney Problems		

Signature_____ Date_____

CHILD