CAPOGNA ORTHODONTICS

1023 N BROADWAY
MASSAPEQUA, NY 11758
P: 516•752•9060
F: 516•752•1432

41 NEW HYDE PARK RD
GARDEN CITY, NY 11530
P: 516•673•4888
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DEMOGRAPHIC INFORMATION

Name ______ Nickname ______
Birthdate ______ Gender ❐ M ❐ F Email ______
Cell Phone # ______ Alt./Home Phone # ______ SSN ______
Home Address [Street Address & Apt#/Floor#] ______
City ______ State ______ Zip ______
Marital Status ❐ Single ❐ Married ❐ Partnered ❐ Separated ❐ Divorced ❐ Widowed
Employment Status ❐ Student ❐ Full Time ❐ Part Time ❐ Self Employed ❐ Retired ❐ Unemployed
Employer Name ______ Employer Address ______
Employer Phone City State Zip

DENTAL INSURANCE INFORMATION

Subscriber Name ______ Birthdate ______ SSN ______
Relationship to Patient: ❐ Self ❐ Spouse ❐ Parent ❐ Stepparent ❐ Grandparent ❐ Legal Guardian
Insurance Name ______ Member ID# ______
Group#/Plan # ______ Insurance Phone ______
Employer Name ______ Employer Address ______
Employer Phone City State Zip

SECONDARY/OTHER DENTAL INSURANCE

Subscriber Name ______ Birthdate ______ SSN ______
Relationship to Patient: ❐ Self ❐ Spouse ❐ Parent ❐ Stepparent ❐ Grandparent ❐ Legal Guardian
Insurance Name ______ Member ID# ______
Group#/Plan # ______ Insurance Phone ______
Employer Name ______ Employer Address ______
Employer Phone City State Zip

REFERRAL INFORMATION

To whom may we thank for referring you to us? ______
Please list any family members who are patients of ours

DENTAL HISTORY & INITIAL INTAKE

General Dentist Name / Dental Practice Name ______
Address [Street Address & Apt#/Floor#] ______
City ______ State ______ Zip ______ Last Dental Exam ______

Reasoning for Consultation ❐ Braces ❐ Invisalign ❐ Other: ______
Previous Orthodontic Treatment? ❐ No ❐ Yes (describe): ______
Have you ever been advised that you require antibiotics prior to a dental appointment?
❐ No ❐ Yes (describe): ______

Have you have, or ever had any of the following dental conditions? ** *Please check all that apply*

❐ NOT APPLICABLE
❐ Injuries to face/mouth/teeth
❐ Teeth grinding
❐ Facial surgery
❐ Missing permanent teeth
❐ Extra permanent teeth
❐ Jaw clenching
❐ Oral surgery
❐ Gum infection / disease
❐ Clicking or popping jaw
❐ Gag easily
❐ Night guard
❐ Sensitive/bleeding gums
❐Active decay of teeth/gums
❐ Sensitive/aching teeth
❐ Loose teeth

Do you have any other dental conditions or problems that are not listed which we should know about? ❐ No ❐ Yes (describe): ______

MEDICAL HISTORY

Physician Name / Practice Name ______
Address [Street Address & Apt#/Floor#] ______
City State Zip Last Medical Exam

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MEDICAL HISTORY (CONTINUED…)

Are you currently being treated by a physician for a specific condition? ❐ No ❐ Yes (describe): ____________

Have you recently been hospitalized or had a major operation? ❐ No ❐ Yes (describe): ____________

Are you taking medication, pills or drugs? ❐ No ❐ Yes (describe): ____________

Do you use tobacco? ❐ No ❐ Yes

Have you ever had an adverse reaction or allergies to any medication or substance?

❐ NO ALLERGIES	❐ Aspirin	❐ Penicillin	❐ Latex
❐ Metals / Nickel	❐ Plastics	❐Other (describe below)	

Please explain any other allergies to medicines, foods, or anything other than what is not listed above ____________

Do you have, or have you ever had any of the following medical conditions?

❐ NOT APPLICABLE	❐ ADD / ADHD	❐ Anemia	❐ Asthma
❐ Bleeding problems	❐ Bone Disorders	❐ Cancer	❐ Diabetes
❐ Endocrine disorders	❐ Epilepsy	❐ Fainting / dizziness	❐ Handicap/disabilities
❐ Hearing impairment	❐ Heart disorders	❐ Hemophilia	❐ Hepatitis
❐ HIV / AIDS	❐ Kidney disorders	❐ Liver involvement	❐ Lupus
❐ Pregnant	❐ Rheumatic fever	❐ Tuberculosis (TB)	❐Other (describe below)

Please explain any other medical conditions other than what is listed above ____________

GUARDIANS OF A MINOR

If you are the patient, please disregard this section and check "Not Applicable**" ❐ **NOT APPLICABLE**

Child's School ____________ **Hobbies/Sports** ____________

Musical Instruments played? ❐ No ❐ Yes (list): ____________

Parents Marital Status ❐ Single ❐ Married ❐ Partnered ❐ Separated ❐ Divorced ❐ Widowed

Who does the child live with? ❐ Guardian1 ❐ Guardian 2 ❐ Both Guardian 1 & 2

Who has legal custody of the child? ❐ Guardian1 ❐ Guardian 2 ❐ Both Guardian 1 & 2

Who is the financially responsible party? ❐ Guardian1 ❐ Guardian 2

Who should be the primary contact? ❐ Guardian1 ❐ Guardian 2

GUARDIAN 1 Name ____________

Relationship to Patient: ❐ Parent ❐ Stepparent ❐ Grandparent ❐ Legal Guardian ❐ Other:____________

Birthdate ____________ Gender ❐ M ❐ F Email ____________

Cell Phone # ____________ Alt. / Home Phone # ____________

Home Address [Street Address & Apt#/Floor#] ❐ SAME AS PATIENTS ____________

City ____________ State ____________ Zip ____________ SSN ____________

GUARDIAN 2 Name ____________

Relationship to Patient: ❐ Parent ❐ Stepparent ❐ Grandparent ❐ Legal Guardian ❐ Other:____________

Birthdate ____________ Gender ❐ M ❐ F Email ____________

Cell Phone # ____________ Alt. / Home Phone # ____________

Home Address [Street Address & Apt#/Floor#] ❐ SAME AS PATIENTS ____________

City State Zip SSN

HABITS OF A MINOR

Has your child ever experienced any of the following? ❐ NOT APPLICABLE

❐ Clenching/Grinding	❐ Nursing/Bottle habits	❐ Lip Sucking/Biting	❐ Speech Problems
❐ Mouth Breather	❐ Thumb/Finger Sucking	❐ Nail Biting	❐ Tongue Thrust

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THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I authorize the dental staff to perform the necessary dental services that my child may need.

❒ Self ❒ Parent ❒ Other:

Signature of Patient and/or Legal Guardian ***Today's Date*** ***Relationship to Patient***

ACKNOWLEDGEMENT

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

If this office accepts insurance, 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. I hereby authorize payment of the group insurance benefits directly to the office.

❒ Self ❒ Parent ❒ Other:

Signature of Patient and/or Legal Guardian ***Today's Date*** ***Relationship to Patient***

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*** You may refuse to sign this acknowledgement ***

I, ______________________________, have received a copy/explanation of this office's Notice of Privacy Practices.

❒ Self ❒ Parent ❒ Other:

Signature of Patient and/or Legal Guardian ***Today's Date*** ***Relationship to Patient***