Dr. Steven A. Fischman Orthodontics 9 Dale Street West Hartford, CT 06107 860-236-8376

## Patient Information

Patient name:______________________________ Date of birth:__________ Sex:______
Nickname/preferred name:____________________ Email:______________________________
Home phone:______________ Cell phone:__________________ Work phone:__________________
Patient address:______________________ City:__________________ State:______ Zip:________
How were you referred to our office: ________________________________________________
School/employer:________________ Hobbies/sports/instruments played:____________________

***If patient is a minor, parent/guardian name(s):***

Mrs./Ms./Miss/Mr./Dr.________________________ Single/Married/Separated/Divorced/Widowed
Address:___________________________ City:__________________ State:_______ Zip:_______
Cell:________ Home:________ Work:________ Email:____________________________________

Mrs./Ms./Miss/Mr./Dr.________________________ Single/Married/Separated/Divorced/Widowed
Address:___________________________ City:__________________ State:_______ Zip:_______
Cell:________ Home:________ Work:________ Email:____________________________________

## Medical History

Allergies: ___Drug ___Latex ___ Metal ___Other: ______________________________________
Does patient require premedication for dental visits? ______________________________
Has patient ever had a blood transfusion? __________________________________________
Has the patient had any of the following: (please circle)

| | | | | |
|---|---|---|---|---|
| Autism | Frequent headaches | Excessive bleeding | Sinus problems | Nail biting |
| Diabetes | Heart murmur | Thyroid problems | Throat infections | Teeth grinding/clenching |
| Epilepsy | TB | Asthma | ADD/ADHD | Lip or tongue biting |
| Heart disease | Frequent colds | Kidney problems | Difficulty breathing | Speech impairment |
| Arthritis | Liver disease | Dizziness/fainting | Bleeding gums | Mouth breathing |
| Hepatitis | Tonsils/adenoids | TMJ disease | Immune disorder-________________ | |

Are there any behavioral, psychological or special needs that we should be aware of? ________________
Physician:__________________ Medication regularly taken:______________________________

## Dental History

Dentist name: __________________ Last dental visit: ________ Chief dental complaint: __________
Has patient ever had orthodontic evaluation or treatment? ______ If yes, by whom? ______________
Is there a history of trauma to teeth or face? ______________________________________
If patient is a minor, did either parent have orthodontic treatment? _____________________
Is there a family history of impacted (un-erupted) canines? ____________________________
Chief dental complaint: ______________________________________________________

______________________________________ ______________________

*Medical/dental history reviewed by Steven A. Fischman, D.M.D.* *Date*

## Dental Insurance

| Primary | Secondary |
|---|---|
| Insurance Co. name: ____________________ | Insurance Co. name: ____________________ |
| Insurance Co. address: ____________________ | Insurance Co. address: ____________________ |
| Group #: ____________________ | Group #: ____________________ |
| Subscriber ID#: ____________________ | Subscriber ID#: ____________________ |
| Insured's name: ____________________ | Insured's name: ____________________ |
| Insured's relationship to patient: ____________ | Insured's relationship to patient: ____________ |
| Insured's date of birth: ____________________ | Insured's date of birth: ____________________ |
| Insured's employer: ____________________ | Insured's employer: ____________________ |

**I authorize Dr. Steven A. Fischman to release any radiographs or other records regarding my orthodontic treatment or my child's orthodontic treatment to appropriate dental care providers.**

______________________________________ ______________________

*Signature of patient (parent or guardian if patient is a minor)* *Date*

**I have received a copy of the HIPAA Notice of Privacy Practices for the office of Dr. Steven A. Fischman Orthodontics**

______________________________________ ______________________

*Signature of patient (parent or guardian if patient is a minor)* *Date*