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

Patient Information

Name:_____ Date of birth:_____ M/F
Nickname:_____ Email:_____
Patient address:_____ City:_____
State:_____ Zip:_____ School/employer:_____
Home #:_____ Cell #:_____ Work #:_____
How were you referred to our office:
_____

Parent/guardian information if patient is under the age of 18

Mrs./Ms./Miss/Mr./Dr._____ Single/Married/Separated/Divorced/Widowed
Address:_____ City:_____
State:_____ Zip:_____ Email:_____
Home#:_____ Cell#:_____ Work#:_____

Mrs./Ms./Miss/Mr./Dr._____ Single/Married/Separated/Divorced/Widowed
Address:_____ City:_____
State:_____ Zip:_____ Email:_____
Home#:_____ Cell#:_____ Work#:_____

Dr. Fischman provides a complimentary intial evaluation. Your account and insurance information will allow us to provide an explanation of your orthodontic benefits and an explanation of how billing may be set up once treatment begins. Our office staff will always inform you before any charges are incurred.

Dental Insurance (please bring your insurance card(s) to your first appointment)

Primary Dental Insurance _____
Ins. company address: _____
Ins. company phone #: _____ Name of subscriber: _____
Date of birth of subscriber: _____ Subscriber's relationship to patient:_____
Subscriber's employer:_____
Ins. ID or SSN#: _____ Ins. group #: _____

Secondary Dental Insurance _____
Ins. company address: _____
Ins. company phone #: _____ Name of subscriber: _____
Date of birth of subscriber: _____ Subscriber's relationship to patient:_____
Subscriber's employer:_____
Ins. ID or SSN#: _____ Ins. group #: _____

-please continue onto the other side-

Medical History

Does patient have any of the following allergies?: Latex Medicine Seasonal Food Metal
Please specify:_____

Does patient require premedication for dental visits? Yes No

Is the patient pregnant or is there a chance the patient may be pregnant? Yes No

Please circle all that apply, including any social, behavioral or developmental information that will help us to provide the best care:

ADD/ADHD Autism Arthritis Asthma Bleeding gums Cancer
Diabetes Dizziness/fainting Earaches Epilepsy Excessive bleeding
Frequent headaches Immune Disorder Hearing impairment Heart murmur
Hepatitis HIV+/AIDS Mouth breathing Speech impairment Teeth grinding/clenching
Thumb/pacifier habit TMJ disease Tuberculosis Visual impairment
Please explain:_____
_____

Medication regularly taken:_____
Physician:_____

Dental History

Dentist name: _____ Last dental visit: _____
Chief orthodontic 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? _____

The information that I have provided is correct, to the best of my knowledge, and I will inform Dr. Steven A. Fischman Orthodontics of any changes.
I authorize Dr. Steven A. Fischman Orthodontics to release and request any radiographs or other records regarding my orthodontic treatment or my child's orthodontic treatment to and from other 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*

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