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: _____

Home Phone: _____ Bus/Cell Phone: _____

Person Financially Responsible For This Account: _____

Address: _____

Home Phone: _____ Bus/Cell Phone: _____

Email Address: _____

Dental Insurance Information

Primary Ins. Carrier	**Secondary Ins. Carrier**
Subscriber: _____	**Subscriber: _____**
SS #: _____ _____	SS #: _____
Ins. Name: _____	Ins. Name: _____
Ins. Address: _____	Ins. Address: _____
Ins. Phone #: _____	Ins. Phone #: _____
Flex Spending acct. ( )yes ( )no	Flex Spending acct. ( )yes ( )no

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

Name of dentist: _____ Date of last visit: _____

Have you seen any other orthodontist relative to this case ? _____

Do you currently grind or clench your teeth? ( )Yes ( )No

Does your jaw ever “click, pop, or lock” upon opening/closing? ( )Yes ( )No

Have you ever experienced pain in or around the ear or jaw? ( )Yes ( )No

Has there ever been a history of trauma to your front teeth? ( )Yes ( )No

ADULT

(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_____