WANTAGH *FAMILY* ORTHODONTICS PC

HARRY J. TSOTSOS, D.M.D.

Acquaintance Card Today's date_______________

Patient's Name____Date of Birth_________
Last First Initial

Address____Zip___________
Street Town

Age_________Sex_________Social Security #______________Home Phone #____________

Dentist___________________Physician_______________Referred by___________________

For minors:

Father's name______________________Cell Phone____________Bus. Phone__________

Mother's name______________________Cell Phone____________Bus. Phone__________

Parent/Parents: Single___ Married____ Divorced___ Separated___ Widow___

Names and ages of other children in family____

E-mail address ________________________________

DENTAL INSURANCE INFORMATION ONLY:

Primary insurance --- Insurance company name________________________________

Group #____

Insured's Name_________________________________Date of Birth_____________

Insured's Address____Zip_________

Occupation____

Employer's Name____

Employer's Address____

Employer's Phone #_____________________________ S.S.#___________________

I authorize the release of medical information to Dr. Harry J. Tsotsos. I also authorize payments of benefits by insurance carrier for services rendered. I will be responsible for all bills not paid by my insurance carrier.

Date_______________Signature___________________________

DENTAL INSURANCE INFORMATION ONLY:

Secondary insurance -- Insurance company name______________________________

Group #____

Insured's Name_________________________________Date of Birth_____________

Insured's Address____Zip_________

Occupation____

Employer's Name____

Employer's Address____

Employer's Phone #_____________________________ S.S.#___________________

I authorize the release of medical information to Dr. Harry J. Tsotsos. I also authorize payments of benefits by insurance carrier for services rendered. I will be responsible for all bills not paid by my insurance carrier.

Date_______________Signature___________________________

TURN OVER & COMPLETE OTHER SIDE

PATIENT'S NAME____

MEDICAL HISTORY -- (List where applicable)

Height________ Weight______
Does patient have tendency for: colds___ sore throats___ ear infections___
Has tonsils and adenoids been removed? ____ What age?___
List any broken bones:____
____
List any drugs or medications now being taken-Give reasons:________________
____
List any drug allergies or sensitivity:___________________________________
____
Does patient bleed easily? Yes___No___
Have high fever with childhood diseases? Yes__No__
If patient is a minor, has patient reached Puberty? Yes___ No___
Does patient vomit, gag or faint easily? __________________________________

CHECK ANY OF THE FOLLOWING FOR WHICH YOU HAVE BEEN TREATED:

Diabetes	__	Bone Disorders	__	Epilepsy	__	Prolonged Bleeding	__
Pneumonia	__	Hepatitis A,B or C	__	Asthma	__	Liver Involvement	__
Heart Trouble	__	Tuberculosis	__	Anemia	__	Kidney Involvement	__
HIV(Aids Virus)	__	Rheumatic Fever	__	Mental Illness	__	Fainting & Dizziness	__
Other	__	Endocrine or Thyroid	__			Nervous Disorders	__

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? Date_________
Has patient ever sucked a thumb or fingers? Yes __ No __ What age?_________
Lip or nail biting?___________________
Does patient have any speech problems?______________________________________
____
Is patient a mouth breather? Yes __ No__ While awake?___ While asleep ___
Have you been informed of any missing or extra permanent teeth?_______________
Has an orthodontist been consulted previously?_______________________________
List any musical instruments played with mouth or lips:_______________________
Any clicking or discomfort of the jaw joint near ears?_______Right?___ Left?___
Any apprehension or unfavorable experience in dental office? _________________
____
Last visit to a dentist ____
Any x-rays taken? ____

What would you wish to gain by orthodontic treatment? _______________________
____

Doctor's Comments:____
____
____
____