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Orthodontics for Children and Adults

PATIENT'S NAME (PRINT) _____ MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE (HOME#) _____ (CELL#) MOM _____ DAD _____

(WORK#) MOM _____ DAD _____ WOULD YOU LIKE TEXT MESSAGE REMINDERS OF APPOINTMENTS? YES OR NO

REFERRED BY _____ PARENT'S E-MAIL _____

SCHOOL _____ GRADE _____

BIRTHDATE _____ BIRTHPLACE _____

DENTIST'S NAME & ADDRESS _____ DATE OF LAST DENTAL CHECKUP _____

PHYSICIAN'S NAME _____ DATE OF LAST MEDICAL CHECKUP _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER'S DATE OF BIRTH _____ MOTHER'S DATE OF BIRTH _____

FATHER'S SOCIAL SECURITY # _____ MOTHER'S SOCIAL SECURITY # _____

FATHER'S EMPLOYER & ADDRESS _____ MOTHER'S EMPLOYER & ADDRESS _____

PARENT'S MARITAL STATUS: MARRIED () DIVORCED () WIDOWED () SEPARATED () NAME(S) AND AGE(S) OF SIBLINGS _____

****TO PROPERLY VERIFY YOUR INSURANCE PLEASE PROVIDE US WITH THE RESPONSIBLE PARTY'S SOCIAL SECURITY # (S) AND A COPY OF YOUR INSURANCE CARD(S)**

DO YOU HAVE DENTAL INSURANCE YES OR NO (IF "YES" PLEASE PROVIDE US WITH THE INSURANCE INFORMATION BELOW)

DENTAL INSURANCE PROVIDER(S) PRIMARY INSURANCE: _____ WHO IS THE INSURED: MOM DAD OTHER

SECONDARY INSURANCE: _____ WHO IS THE INSURED: MOM DAD OTHER

1. WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS? _____
2. IS YOUR CHILD IN GOOD HEALTH? _____
3. DOES YOUR CHILD HAVE REGULAR MEDICAL EXAMINATIONS? _____
4. HAS YOUR CHILD EVER HAD/HAVE ANY OF THE FOLLOWING: PLEASE CHECK ALL THAT APPLY: NONE

<input type="checkbox"/> HAY FEVER <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> EPILEPSY <input type="checkbox"/> HEPATITIS <input type="checkbox"/> HIVES <input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> AUTISM / ASD	<input type="checkbox"/> DIABETES <input type="checkbox"/> ASTHMA <input type="checkbox"/> JAUNDICE <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> ANEMIA <input type="checkbox"/> TOURETTE SYNDROME	<input type="checkbox"/> CHRONIC HEADACHES <input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> BLOOD DISORDERS <input type="checkbox"/> SNORING <input type="checkbox"/> SLEEP APNEA <input type="checkbox"/> ADHD	<input type="checkbox"/> ENDOCRINE /THYROID PROBLEMS <input type="checkbox"/> MITRAL VALVE PROLAPSE <input type="checkbox"/> DOES YOUR CHILD NEED PREMEDICATION? <input type="checkbox"/> RHEUMATOID/ARTHRITIC CONDITIONS <input type="checkbox"/> HANDICAP/DISABILITES <input type="checkbox"/> NIGHT TERRORS <input type="checkbox"/> OTHER _____
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5. YOUR CHILD EXPERIENCED ANY ALLERGIC REACTIONS TO DRUGS, METALS OR LATEX? _____
6. IS THERE A HISTORY OF THUMB OR FINGER SUCKING? IF YES, PLEASE EXPLAIN _____
7. IS YOUR CHILD A MOUTH-BREATHER? IF YES, PLEASE EXPLAIN _____
8. HAS YOUR CHILD ANY HISTORY OF SPEECH PROBLEMS? _____
9. IS THERE A HEREDITARY BACKGROUND THAT MIGHT CONTRIBUTE TO YOUR CHILD'S DENTAL PROBLEM? _____
10. HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH, TEETH OR CHIN? IF YES, PLEASE EXPLAIN _____
11. HAS YOUR CHILD EVER HAD ANY PAIN/TENDERNESS IN HIS/HER JAW JOINT (TMJ)? _____
12. HAVE ADENOIDS OR TONSILS BEEN REMOVED? _____
13. IS YOUR CHILD TAKING ANY MEDICATIONS? _____ IF SO, WHICH MEDICATIONS _____
14. FOR WHAT CONDITION? _____

I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT _____
SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____