LIEBERMAN & JAIN ORTHODONTICS
Orthodontic Specialists for Children and Adults

DR. LAWRENCE LIEBERMAN, DDS, MSD
DR. PAYAL JAIN, BDS, DDS

ORTHODONTIC SPECIALISTS
FOR CHILDREN AND ADULTS
289 Market Street, Suite # 8, Saddle Brook, NJ 07663
BergenCountyBraces@gmail.com
www.BergenCountyBraces.com
P-201-843-7064 F-203-843-4709

New Patient Form – Child

(Please fill, save, print and bring with you)

GENERAL INFORMATION

Today's Date:

Patient's Name: Date of Birth:

Age: ☐ Male ☐ Female Social Security Number:

Home Address:

Home Phone #: Cell Phone #:

E-mail Address: Would you like to receive email confirmation? ☐ Yes ☐ No

Patient's School: Grade:

Hobbies/Interests:

List Siblings with age:

How did you hear about us?

MAIN CONCERNS/REASONS FOR DESIRING ORTHODONTICS?

RESPONSIBLE PARTY INFORMATION

Person responsible for Payment:

MARITAL STATUS: ○ Single ○ Married ○ Divorced ○ Widowed ○ Other

Mother's Name: Date of Birth:

Home Phone: Cell phone: Work Phone:

E-mail Address: Would you like to receive email confirmation? ☐ Yes ☐ No

Address if different:

Employer: Occupation: SSN:

Father's Name: Date of Birth:

Home Phone: Cell phone: Work Phone:

E-mail Address: Would you like to receive email confirmation? ☐ Yes ☐ No

Address if different:

Employer: Occupation: SSN:

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DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name:

ID #: Group #: Insurance Co. Phone #:

Insurance Co. Address:

Insured's Name: Relationship:

Insured's Birthdate: Insured's Social Security #:

Insured's Employer:

Secondary Insurance

Insurance Co. Name:

ID #: Group #: Insurance Co. Phone #:

Insurance Co. Address:

Insured's Name: Relationship:

Insured's Birthdate: Insured's Social Security #:

Insured's Employer:

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature: ___________________________________

Updates: Date: Initial:

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MEDICAL HISTORY

Physician: ☐

Last Visit Date: ☐ Office Phone #: ☐

Address: ☐

Do Any Of The Following Apply To Your Child?

☐ Yes ☐ No Allergies (Latex/Medications/Food) Please specify: ☐
☐ Yes ☐ No Anemia (Type: ☐)
☐ Yes ☐ No Hemophilia / Abnormal Bleeding
☐ Yes ☐ No Blood transfusion
☐ Yes ☐ No Cancer / ☐ Radiation/Chemotherapy
☐ Yes ☐ No High / ☐ Low Blood Pressure
☐ Yes ☐ No Diabetes (Type: ☐)
☐ Yes ☐ No Epilepsy / Seizures / Fainting Spells
☐ Yes ☐ No Severe / Frequent Headaches
☐ Yes ☐ No Bone Disorders ☐
☐ Yes ☐ No Artificial / ☐ Replacement Joints
☐ Yes ☐ No Arthritis
☐ Yes ☐ No HIV+ / ☐ AIDS
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Hepatitis (Type: ☐)
☐ Yes ☐ No Gastrointestinal Disorders: ☐
☐ Yes ☐ No Smoking
☐ Yes ☐ No Drug / Alcohol Abuse
☐ Yes ☐ No Fever Blisters / Herpes
☐ Yes ☐ No Pregnant (presently)
☐ Yes ☐ No Any Cardiac Conditions (Congenital Heart Defects, Artificial Valves, Rheumatic/Scarlet Fever, Heart Surgery, Pacemaker, Heart Attack, Stroke, Heart Murmur)
☐ Yes ☐ No Any Respiratory Conditions (Asthma, Sinus Issues, Tuberculosis, Tonsil or Adenoid Removal)
☐ Yes ☐ No Any neurological/psychological/emotional/developmental conditions (hypersensitivity, ADHD, ADD, Autism etc.) ☐
☐ Yes ☐ No Have you been hospitalized for any reason? ☐
☐ Yes ☐ No Are you currently under care of a physician? ☐
☐ Yes ☐ No Have you taken any Bisphosphonate Preparations (Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa)
☐ Yes ☐ No Are you taking any medication? Please list all ☐

Are there any medical conditions we have not discussed that you feel we should be aware of?

☐

Has Puberty begun? ☐ Yes ☐ No ☐ Not sure
Female Patients only: Has menstruation started? ☐ Yes ☐ No If yes when ☐
Male Patients only: Has voice changed? ☐ Yes ☐ No

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DENTAL HISTORY

Family Dentist: ______

Last Visit Date: ______ Office Phone #: ______

Address: ______

Do Any Of The Following Apply To Your Child?

☐ Yes ☐ No Any Habits like thumb sucking, lip sucking Or Biting, tongue thrusting, Nail Biting, Mouth Breathing

If YES please Specify ______

☐ Yes ☐ No Have you ever experienced locking? (Open lock or closed lock) OR any limited range of motion

☐ Yes ☐ No Do you clench / grind teeth?

☐ Yes ☐ No Have you ever experienced pain / discomfort in the jaw joint (TMJ)?

If YES, are you currently being treated for the above? ______

Any injuries to the: ☐ Face ☐ Mouth ☐ Teeth ☐ Chin ______

☐ Yes ☐ No Have you ever been diagnosed with Gingival (Gum) Disorder?

☐ Yes ☐ No Do you need to be pre-medicated with an antibiotic prior to invasive dental procedures that will cause bleeding because of a heart problem? ______

Have you ever experienced any unfavorable reaction to dentistry? ______

Are there any other dental conditions we have not discussed that you feel we should be aware of?

______

ORTHODONTIC HISTORY

☐ Yes ☐ No Have you had previous orthodontic treatment? ______

☐ Yes ☐ No Have you consulted another orthodontist? ______

☐ Yes ☐ No Do you have any other family member(s) that are currently being treated orthodontically?

If YES, please list and explain: ______

Are you aware that some appointments may be during school hours? ______

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, **I authorize the dental staff to perform any dental services that I/my child may need during the diagnosis and treatment with my informed consent**

Signature: ______________________________ Date: ______