Margot Jaffe, DDS
Pediatric Dentist and Orthodontist
Suzanne Duvalsaint, DDS
Orthodontist
Caryn Siegel, DMD
Pediatric Dentist

Cecilia Kolstad, DMD
Pediatric Dentistry

110 East 87th Street NY, NY 10128
(212) 369-2213 Fax: (212) 369-1338

Corey Turk, DDS
LeeAnn Clark, DDS
Keith Goldman, DMD
Orthodontics

130 West 86th Street, NY, NY 10024
(212) 362-3355 Fax: (212) 362-3356

ADULT ORTHODONTIC PATIENT INFORMATION:

Name: ______________________________________Date Of Birth:____________________________

Home Phone #:____________________Cell Phone #:____________________(preferred number?)

Address: ____Apt.#: ___________________________

City: ______________________________ State: _________Zip Code:_________________________

Occupation: _______________________________________ Work #___________________________

Email address:____________________________Emergency Contact: __________________________

Primary Physician:_________________________________Phone #:__________________________

Date of last physical exam: ____

General Dentist: ___________________________________ Phone #:___________________________

Other Dental Specialists: ___________________________ Phone #:___________________________

Whom may we thank for referring you?____

Are there any other family members who are patients at this office? _________________________

DENTAL HISTORY:

Are you having any dental discomfort?____
Have you had previous orthodontic treatment? Y N Date:____________________________
Any injuries to teeth or face? _____ If yes, please explain: __________________________________
Bleeding/Sore gums?____
Do you know of any sore spots or growths in/around mouth?________________________________
Do you feel there is anything wrong with your teeth? ______ Please explain____________________
____

(OVER)

Oral Habits

How often do you brush your teeth? _____________ Floss? ______________________________
Do you grind your teeth? ____
Do you experience any TMJ discomfort? ____
Do you use any tobacco products? ____
Do you use any prescription oral care products? _______________________________________

MEDICAL HISTORY:
Have you ever had any of the following?
Please circle all that apply:

Visual Disorder
Rheumatoid Arthritis
Rheumatic Heart Disease
Sinus problems
Asthma
Tuberculosis
Respiratory Problems
Heart Murmur
Cardiac Problems
Liver disease/Hepatitis
Renal/ Kidney Disease
Intestinal Problems
Muscular Disorder
Coordination Problems
Hearing disorder
Anemia
Prolonged Bleeding
Diabetes
Thyroid Problems
Neurological Disorder
Convulsions/Seizures
Fainting
Tumors
ADD/ADHD
Oral Herpes
Osteoporosis
Major/Minor surgery
Hospitalizations

If female, are you or might you be pregnant? Y N

Do you take any medication for osteoporosis (osteoclast inhibitors)? Y N

Please list any other medications that you may be taking:_________________________________
____

Please list any allergies to medication: ____

Other allergies: ____

Latex Sensitivity? Y N

Have you ever had any illness or condition not mentioned above? Y N (if yes please explain)

____

Do you undergo regular MRI's for any reason? ____

Have you had any unusual experience with anesthetic? ___________________________________

Any additional information you think we should know?____________________________________

Consent For Treatment

I hereby consent to dental procedures and techniques which Dr.'s Margot Jaffe, D.D.S., Suzanne Duvalsaint, D.D.S, & Caryn Siegel, D.M.D. and their associates deems necessary for the treatment. I authorize the dentist to provide any information to the other doctors for the purpose of consultation. I understand that prior to any treatment, I will be advised about it by the dentist or hygienist, that I may ask questions concerning it, and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of the patient.

Signature:____ Date:___________

---please do not write below this line -------------------------------------

Reviewed By: ____________________________________D.D.S., D.M.D., R.D.H. Date:___________

PLEASE TAKE NOTE OF OUR OFFICE POLICIES:

Missed appointments:
If you are unable to keep your appointment, please notify us at least 24 hours in advance. We would be glad to reschedule the appointment at a more convenient time if necessary. We reserve the right to charge for missed appointments.

Emergencies:

Unfortunately dental emergencies do arise. We will assess your emergency on the phone and make every effort to make an appropriate appointment to address the situation. We prefer to see emergencies in the earlier part of the day when the office tends to be quieter. We also ask for your patience when we might be delayed in seeing you or your child due to an urgent situation with another patient.

FINANCIAL POLICY:
We are delighted to welcome you to our practice and we are pleased that you chose us to serve your dental needs. The following is a statement of our financial policy, which we require you to read and sign and the bottom of this page:

Payment is expected at the time services are rendered; our practice does not participate with insurance, we will give you a Doctor's statement (Insurance form), and the member will be responsible for submitting the information to the Insurance Company for reimbursement.

Payment methods:
We accept Visa, Master Card, American Express, Discover, Personal checks*, and Cash.

*All returned checks are subject to a twenty-five dollar service charge.

For your convenience, you may elect to keep a credit card on file with our office.

___ I do not authorize any credit cards to be on file.

___ I hereby authorize MARGOT JAFFE, D.D.S. & SUZANNE DUVALSAINT, D.D.S., & CARYN SIEGEL, D.M.D.to keep my credit card on file, in which it could be used to charge for any visits, as well as to clear any balances on my account. We will mail you a statement with a copy of your credit card receipt.

Card Type: ________________CC#: ____

Exp. Date: ________________ Billing Zip Code: ____________________________________

Cardholder's Name: ____

Signature: ____

BY SIGNING BELOW, I UNDERSTAND AND AGREE TO THESE POLICIES

Signature:_______________________________________ Date:_______________