NY Kids Dentistry and Orthodontics

110 E. 87th Street, #1A, New York, NY 10128
212-369-2213

130 W. 86th Street, #1A, New York, NY 10024
212-362-3355

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_____
_____

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? _____

Suzanne Cirino Duvalsaint, DDS, MS
Orthodontics

Caryn Siegel, DMD
Diplomate,
American Board of
Pediatric Dentistry

Margot Jaffe, DDS
Keith Goldman, DMD
Yena Jun, DDS
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Cecilia Kolstad, DMD
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MEDICAL HISTORY:

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

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

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Consent For Treatment

I hereby consent to dental procedures and techniques which Drs 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:_____

Reviewed By: _____D.D.S., D.M.D., R.D.H. Date:_____

OFFICE POLICIES:

Missed appointments:

If you are unable to keep your appointment, we would appreciate at least 24 hours notice if at all possible. This will help us utilize that time for another patient who requires an appointment. We would be glad to reschedule your 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 make every effort to assess your emergency on the phone and schedule an appropriate appointment. Based on our experience and the type of emergency we can determine how urgently we need to see you. We also ask for your patience when we might be delayed in seeing you due to an urgent situation with another patient.

Acknowledgement of receipt of Notice of Privacy Practices:

I_____, hereby acknowledge that I have been given the right to review JAFFE, D.D.S., DUVALSAINT, D.D.S, & SIEGEL, D.M.D.

Patient's Signature: _____
Print Name:_____

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Financial Policy:

We value you and your family as patients and appreciate that you have entrusted us with your dental needs. The following is a statement of our financial policy which we require you to read and sign at the bottom of this page:

As you know there is a charge for the pediatric dental and orthodontic services that we provide. Payment is expected at the time services are rendered. For Pediatric dental visits, as a courtesy we are happy to complete all necessary documentation and submit it to your insurance provider, for reimbursement directly back to you. For all Orthodontic services, a form will be provided and you will be responsible for submitting to your insurance company for reimbursement. (Please see the front desk for more information).

Please bring your insurance information and a valid ID to your or your child's visit.

Since you are ultimately responsible for payment for treatment it is our policy to obtain your credit card number and authorization to process claims for payments. By presenting your credit card to the receptionist at the front desk, you authorize without prior notification, payment by credit card for services for the amounts you are obligated to pay (for both pediatric dental and orthodontic services). If you would like to use an alternative method of payment please inform us prior to the appointment.

I hereby authorize JAFFE, D.D.S., DUVALSAINT, D.D.S, & SIEGEL, D.M.D. to keep my credit card on file, which it could be used to charge any visits my child has, as well as to clear any balances on my account.

☐ I choose **NOT TO** leave a credit card on file and I understand that payment in full is due at the time of service. **Late payments will incur a 2% administrative fee.**

Any patients entering or enrolled in a payment plan for orthodontic treatment are required to leave a credit card on file.

There may be a cancelation/no show fee if the patient is not able to make their appointment without giving a 24-hour notice.

Patient's Name: _____ Parent/Guardian's Name _____

Cardholder's Signature:_____Date: _____

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