



1327 Union Street, Schenectady, New York 12308
 Phone: (518) 377-2700 Fax: (518) 346-4347

Date of Appointment:

PLEASE PRINT IN INK

PATIENT INFORMATION

LAST NAME		FIRST NAME	NICKNAME		SEX	BIRTH DATE	AGE
ADDRESS		CITY	STATE	ZIP	HOME PHONE		
SCHOOL (if student)	GRADE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEP <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW(ER)	EMPLOYED BY/OCCUPATION		BUSINESS PHONE		
PARENT/LEGAL GUARDIAN E-MAIL**			CELL PHONE				
WHO MAY WE THANK FOR RECOMMENDING US?		NAME OF DENTIST			DATE OF LAST VISIT		
RELATED PATIENT(S) THAT ARE OR HAVE BEEN UNDER OUR CARE				NAME(S) & AGE(S) OF OTHER CHILDREN			

PARENT/LEGAL GUARDIAN INFORMATION (please complete if patient is a minor)

PARENT/LEGAL GUARDIAN'S NAME _____	PARENT/LEGAL GUARDIAN'S NAME _____
RELATIONSHIP TO PATIENT _____ DOB _____	RELATIONSHIP TO PATIENT _____ DOB _____
ADDRESS (if different from patient's) STREET/P.O. BOX _____	ADDRESS (if different from patient's) STREET/P.O. BOX _____
CITY _____ ST _____ ZIP _____	CITY _____ ST _____ ZIP _____
HOME PHONE _____ WORK _____	HOME PHONE _____ WORK _____
CELL PHONE _____ FAX _____	CELL PHONE _____ FAX _____
EMPLOYER _____	EMPLOYER _____
OCCUPATION _____	OCCUPATION _____
ADDRESS _____	ADDRESS _____
CITY _____ ST _____ ZIP _____	CITY _____ ST _____ ZIP _____

INFORMATION ABOUT PERSON(S) RESPONSIBLE FOR THIS ACCOUNT

NAME		RELATIONSHIP TO PATIENT			
MAILING ADDRESS		CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	CELL PHONE		FAX	
IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?		MAY PATIENT INFORMATION LEGALLY BE RELEASED TO THE NON-CUSTODIAL PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			

Do you have insurance with an orthodontics benefit? Yes No

Do you have a Flexible Spending Account? Yes No

**Any e-mail address provided will only be used for direct contact through our office and will not be used for any other purpose.

DeLuke Orthodontics, PC

MEDICAL HISTORY

Please check if patient has or has had:

- | | |
|---|---|
| Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Joint pain/swelling | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Bone disorders | <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Heart trouble | <input type="checkbox"/> <input type="checkbox"/> Epilepsy (seizures) |
| <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic trouble | <input type="checkbox"/> <input type="checkbox"/> Faintness/Dizziness |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> <input type="checkbox"/> Emotional problems | <input type="checkbox"/> <input type="checkbox"/> Frequent Sore throats |
| <input type="checkbox"/> <input type="checkbox"/> Brain injury | <input type="checkbox"/> <input type="checkbox"/> Frequent Tonsillitis |
| <input type="checkbox"/> <input type="checkbox"/> Kidney/liver disease | <input type="checkbox"/> <input type="checkbox"/> Frequent Earaches |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Asthma |

On items checked "Yes," please provide us with a more detailed description.

Do you smoke or use any tobacco substances? Yes No

Have you or any member of your family or close relative had:
 Rheumatoid arthritis? Yes No Lupus? Yes No

What would you like to have orthodontic treatment accomplish?

List any other serious illnesses:

List any allergies:

List drugs or medications now being taken:

Is patient presently under physician's care?

Reason:

Name of physician:

Primary:

Other:

Other:

Other:

Patient's attitude toward orthodontic treatment:
 (circle one) Very motivated Will cooperate if needed Not motivated

Growth and Development Information:

Adolescent Males: Has puberty begun Yes No
 Adolescent Females: Has menstruation begun: Yes No
 If Yes, Approximate Date (month/year):

Hobbies and/or interests of the patient _____

Release of Information:

I authorize DeLuke Orthodontics, PC to release information to the following individual(s):

Name	Relationship to Patient

To the best of my knowledge, the above information is complete and correct.

_____ Date

_____ Signature of Patient or Parent/Legal Guardian if Patient is a Minor

