MANHATTAN FAMILY ORTHODONTICS

Kris Togias, D.M.D., PC
Olivier Nicolay , DDS , MMSc
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

CONFIDENTIAL MEDICAL-DENTAL HISTORY

DENTAL HISTORY – now or in the past have you had (please check):

❒Yes ❒No-Any teeth removed for any reason?_____
❒Yes ❒No-Snoring, sleep apnea? PSG test date _____
❒Yes ❒No-Supernumerary (extra) or congenitally missing teeth? _____
❒Yes ❒No-Tooth grinding, jaw clenching, clicking or locking? _____
❒Yes ❒No-Chipped or otherwise injured primary (baby) or permanent teeth?_
❒Yes ❒No-Pain in jaw? _____
❒Yes ❒No-Teeth sensitive to hot or cold, teeth throb or ache? _____
❒Yes ❒No-Difficulty chewing or jaw opening? _____
❒Yes ❒No-Jaw fractures, cysts or mouth infections? _____
❒Yes ❒No-Aware of loose, broken or missing fillings? _____
❒Yes ❒No-"Dead teeth" or root canals treated? _____
❒Yes ❒No-Any teeth irritating cheek, lip, tongue or palate? _____
❒Yes ❒No-Periodontal problems, bleeding gums? _____
❒Yes ❒No-Frequent canker sores or cold sores? _____
❒Yes ❒No-Thumb, finger or sucking habit? Until what age? _____
❒Yes ❒No-Any wisdom tooth problems? _____
❒Yes ❒No-History of speech problems? _____
❒Yes ❒No-Wisdom teeth removed? Date _____
❒Yes ❒No-Ever had a prior orthodontic examination or treatment? _____
❒Yes ❒No-Are you sensitive or self-conscious about your teeth? _____
Date of past treatment_____
❒Yes ❒No-Presently wearing retainer/mouth guard? _____
Other concerns about your teeth not listed?
_____

133 East 58th Street, Suite 912 New York, NY 10022
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MEDICAL HISTORY – now or in the past have you had (please check):

❒ Yes ❒ No-Birth defects or hereditary problems? _____
❒ Yes ❒ No-Bone fractures, any major accidents? _____
❒ Yes ❒ No-Rheumatoid or arthritic conditions? _____
❒ Yes ❒ No-Endocrine or thyroid problems? _____
❒ Yes ❒ No-Kidney problems? _____
❒ Yes ❒ No-Diabetes? _____
❒ Yes ❒ No-Cancer, tumor, radiation treatment or chemotherapy? _____
❒ Yes ❒ No-Stomach ulcer, GERD, or frequent heartburn? _____
❒ Yes ❒ No-Problems of the immune system? AIDS or HIV positive? _____
❒ Yes ❒ No-Hepatitis, jaundice or liver problems? _____
❒ Yes ❒ No-Fainting spells, seizures, epilepsy, or neurological problems? _____
❒ Yes ❒ No-Mental health disturbance or behavioral problems? _____
❒ Yes ❒ No-Vision, hearing problems other than corrective lenses? _____
❒ Yes ❒ No-History of eating disorder (anorexia, bulimia)?_____
❒ Yes ❒ No-Excessive bleeding or bleeding disorder? _____
❒ Yes ❒ No-High or low blood pressure? _____
❒ Yes ❒ No-Cardiovascular problems such as chest pain, heart attacks?_____
❒ Yes ❒ No-Hayfever, asthma, sinus trouble? _____
❒ Yes ❒ No-Stroke, inborn heart defects, heart murmurs, angina? _____
❒ Yes ❒ No-Tonsil or adenoid conditions? _____
❒ Yes ❒ No-Does your child chew or smoke tobacco? _____
❒ Yes ❒ No-Girls – are you pregnant? _____

List allergies to all medications, latex, or metals
_____
List all medications, herbal supplements, or vitamins presently taken:
_____
Describe any operations or surgery you have had, including dates:
_____
Are there any other medical conditions that we should be aware of?
_____

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I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice at my next visit. Further more, I consent to an orthodontic examination and treatment of my child.

Signed: _____Date signed _____
(Parent or Guardian)

Signed: _____ Date signed _____
(Dental staff member receiving form)

FINANCIAL AGREEMENT

--- We accept assignment of MOST insurance plans. Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company.
--- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. We estimate your insurance payments according to your policy. WE DO NOT in any way guarantee that your insurance will pay this amount.
--- Your payment is due at every visit unless you have made a financial contract with our office with scheduled payment dates. Cash, check or credit card are expected at the time services are rendered.
--- I hereby authorize payment directly to Kristos Togias, DMD./Manhattan Family Orthodontics (if chosen to)the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.
--- A fee will be charged to your account if there is a history of broken appointments with less than 24 hours notice, including same day cancellations.

Parent or Guardian's Signature _____Date _____

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