Welcome To Our Office!

Dr. Ilya Lipkin, DDS
Diplomate American Board of Orthodontics
Specialty #5308

345 Old Hook Road
Westwood NJ 07675
201.666.4646

PLEASE TELL US ABOUT YOU

Today's Date: _____

Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____ Gender: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____ SS#: _____

Email Address: _____

Hobbies & Interests: _____

Employer: _____ Position: _____

Is it okay to contact you at work? _____ Business Phone: _____

Who may we thank for this referral? _____

RESPONSIBLE PARTY

Person Financially Responsible for this account: _____

If Different from Above, Please fill in name--First: _____ Last: _____

Relationship to Patient: _____

DOB: _____ SS#: _____

Address (if different): _____ City: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

INSURANCE INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Co: _____
Insurance Address: _____
Phone #: _____
Member ID: _____
Group # (plan, local or policy): _____
Subscriber: _____
Relation to Patient: _____
Employer: _____
Birthdate: _____ SS#: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Co: _____
Insurance Address: _____
Phone #: _____
Member ID: _____
Group # (plan, local or policy): _____
Subscriber: _____
Relation to Patient: _____
Employer: _____
Birthdate: _____ SS#: _____

I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination, rendered to my insurance company.

Signature on file for insurance _____ Date _____

MEDICAL AND DENTAL HISTORY

Please answer the following questions to the best of your knowledge

Family/Patient's Dentist: _____ Office Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Name: _____ Office Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

1. Are you now of have you ever been under a physician's care? Yes ☐ No ☐

2. Have you ever been hospitalized? Yes ☐ No ☐ REASON _____

3. Allergies: food, pollen, drugs? Yes ☐ No ☐ EXPLAIN _____

4. Any medical problems? Yes ☐ No ☐

☐ Heart ☐ Kidneys ☐ Lungs ☐ Liver ☐ Blood Disorders ☐ Other _____

5. Has any physician/dentist ever indicated that antibiotics (E.G. Penicillin) be taken prior to a dental procedure? ☐ Yes ☐ No

6. What is your main concern in regards to your teeth / bite?

_____

_____

7. Who first suggested the need for an orthodontic consult / treatment?

☐ Parents ☐ Patient ☐ Dentist ☐ Other _____

8. Previous orthodontic treatment/ consult? ☐ Yes ☐ No May we ask where _____

9. Is there clicking / popping / discomfort with the jaw joints? ☐ Yes ☐ No

10. Are you aware of any grinding or clenching of teeth? ☐ Yes ☐ No

11. Speech or other oral / dental problems? Yes ☐ No ☐

12. When was your last visit to a general dentist?

☐ Recent ☐ 6 or more months ago ☐ more than a year ago ☐ Don't remember

13. Gag reflex? ☐ Yes ☐ No

14. History of facial / tooth trauma? ☐ Yes ☐ No If yes, please explain _____

_____

15. Oral habits: ☐ Thumb / Finger sucking ☐ Lip / Nail biting ☐ Mouth breathing ☐ Tongue thrust

Any other diagnoses you would like to include? _____

*I, the undersigned, give consent to release my information to the emergency contact listed here:

_____ _____ _____

First and Last Name Relationship to Patient Contact

*I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history record, I will so inform this practice. Also, I give consent for this examination and I am legally authorized to do so.

*Today's date _____ *Signature Required _____