

FURINO & HAMLIN

Specializing in Orthodontics • Children and Adults

ANTHONY J. FURINO
DDS MSD

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DDS

Member
American Association of
Orthodontists

Today's Date _____ General Dentist _____
Patient Name _____ Date Of Birth ____/____/____ Age ____
Address _____ Phone _____ SS# ____/____/____
City _____ State _____ Zip Code _____
Immediate Family Members Treated By Drs. Furino & Hamlin _____
Whom May We Thank For Referring You? _____

ADULTS PLEASE CONTINUE AT THE RESPONSIBLE PARTY SELECTION *

Father's Information

Name _____ Date Of Birth _____
Address _____ Phone _____ SS# ____/____/____
City _____ State _____ Zip Code _____
Employer _____ Phone _____
Business Address _____ Zip Code _____

Mother's Information

Name _____ Date of Birth _____
Address _____ Phone _____ SS# ____/____/____
City _____ State _____ Zip Code _____
Employer _____ Phone _____
Business Address _____ Zip Code _____

*** RESPONSIBLE PARTY**

Name _____ Date of Birth _____
Address _____ Phone _____ SS# ____/____/____
City _____ State _____ Zip Code _____
Employer _____ Phone _____
Business Address _____ Zip Code _____

IF YOU HAVE INSURANCE COVERAGE, PLEASE PROVIDE US WITH A COMPLETED FORM

What are the main concerns that you would like orthodontics to accomplish?

- Y N Has The Patient Ever Been Evaluated Or Had Orthodontic Treatment?
Y N Have There Been Any Injuries To The Face, Mouth, Teeth, Or Chin?
Y N Have Adenoids Or Tonsils Been Removed?
Y N Has The Patient Been Informed Of Any Missing Or Extra Permanent
Teeth?
Y N Have You Or Your Child Ever Had Any Pain/Tenderness In The Jaw
Joint? If Yes, You _____ Child _____
Y N Is The Patient Under The Care Of A Physician Currently?

Physician _____ Phone _____

ONE PARIS ROAD	NEW HARTFORD	NEW YORK 13413	TELEPHONE 315 724 5800
338 EAST STATE STREET	HERKIMER	NEW YORK 13350	TELEPHONE 315 866 2344
29 PIONEER STREET	COOPERSTOWN	NEW YORK 13326	TELEPHONE 607 547 2121
10 DIETZ STREET	ONEONTA	NEW YORK 13820	TELEPHONE 607 431 1021

Please List All Drugs That The Patient Is Currently Taking

Please Discuss Any Medical Problems

Does/Did The Patient Have Any Of The Following Habits?

Y	N	Clenching/ Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking/ Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb/ Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Has The Patient Ever Had Any Of The Following?

Y	N	Abnormal Bleeding	Y	N	Heart Surgery/Pacemaker
Y	N	Allergy To Latex/Metals	Y	N	Heart/Murmur
Y	N	Anemia/Radiation Treatment	Y	N	Hemophilia
Y	N	Artificial Bones/Joints	Y	N	Hepatitis
Y	N	Artificial Valves	Y	N	High/Low Blood Pressure
Y	N	Asthma	Y	N	HIV /AIDS
Y	N	Blood Transfusion	Y	N	Kidney/Liver Problems
Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Convulsions/Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Diabetes/Tuberculosis	Y	N	Severe/Frequent Headaches
Y	N	Difficulty Breathing	Y	N	Shingles/Chicken Pox
Y	N	Drug/Alcohol Abuse	Y	N	Sinus Problems
Y	N	Emphysema/Glaucoma	Y	N	Hearing Impaired
Y	N	Fever Blisters/Herpes	Y	N	Ulcers/Colitis
Y	N	Handicaps/Disabilities	Y	N	Onset Of Puberty
Y	N	Heart Attack/Stroke	Y	N	Allergies To Any Drugs(List)

Y N Hospitalized For Any Reason? _____

Y N Is It Necessary To Premedicate Before Dental Procedures?

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services needed.

Signature of Parent Or Guardian Or Self

Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of Parent Or Guardian Or Self

Date