SENESTRARO FAMILY
ORTHODONTICS

WELCOME

To assist us in providing the most complete service, please provide the following information and health history.

PATIENT INFORMATION

Patient Name _____ (FIRST / MIDDLE / LAST) Today's Date _____

Nick Name _____ Sex _____ Age _____ Birth Date _____

Address _____ Home Phone _____

City _____ Zip _____ Cell Phone _____

Cell Phone Provider _____ Email Address _____

Dentist _____ Physician _____

School _____ Siblings/DOB _____

SELF OR PRIMARY GUARDIAN

Name _____

Address _____
(If Different from above)

How long at address _____

Main Contact # _____

Email Address _____

Social Security Number _____

Date of Birth _____

Marital Status _____

SPOUSE OR SECONDARY GUARDIAN

Name _____

Address _____
(If Different from above)

Main Contact # _____

Email Address _____

Social Security Number _____

Date of Birth _____

Marital Status _____

PRIMARY DENTAL INSURANCE ONLY

Ortho Coverage? ☐ **Yes** ☐ **No** **If "Yes" Complete Below**

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # _____
(Plan, Local, or Policy)

Policy Owner's Name _____

ID Number _____

Employer _____

Date of Birth _____

SECONDARY DENTAL INSURANCE ONLY

Ortho Coverage? ☐ **Yes** ☐ **No** **If "Yes" Complete Below**

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # _____
(Plan, Local, or Policy)

Policy Owner's Name _____

ID Number _____

Employer _____

Date of Birth _____

PLEASE COMPLETE OTHER SIDE

SENESTRARO FAMILY
ORTHODONTICS

HOW DID YOU FIND OUR PRACTICE?

- ❑ Referred by my dentist, Dr. _____
- ❑ Referred by a friend/relative _____
- ❑ Direct Mail Invitation
- ❑ I am a former patient
- ❑ Online Search

MEDICAL HISTORY

please check box if patient has or has had:

- ❑ Positive HIV Test
- ❑ Joint Swelling
- ❑ Bone Disorder
- ❑ Heart Trouble
- ❑ Rheumatic Fever
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Emotional Problems
- ❑ Brain Injury
- ❑ Kidney or Liver Involvement
- ❑ Tuberculosis
- ❑ Anemia
- ❑ Asthma
- ❑ Epilepsy
- ❑ Prolonged Bleeding
- ❑ Faintness/Dizziness
- ❑ Tonsils Removed
- ❑ Adenoids Removed
- ❑ Sore Throats
- ❑ Tonsillitis
- ❑ Earaches
- ❑ Taking Fosamax (or other biophosphante for your bones)

List any serious illnesses: _____

List any allergies: _____

List drugs or medications now being taken: _____

_____

Is patient under physician's care presently? _____

Reason: _____

Name of Physician: _____

Additional Comments: _____

_____

DENTAL HISTORY

please check box if answer is yes:

- ❑ Any injuries to: **FACE** **MOUTH** **TEETH** (circle)
- ❑ Mouth-breathing when: **ASLEEP** **AWAKE** (circle)
- ❑ Any sleep apnea issues?
- ❑ Any snoring issues?
- ❑ More than average amount of decay?
- ❑ Any missing permanent teeth?
- ❑ Any teeth removed by extraction?
- ❑ Is there any tongue-trusting problems?
- ❑ Any speech problems?
- ❑ Any difficulty in swallowing or chewing?
- ❑ Any pain or clicking when opening mouth?
- ❑ Does patient visit dentist regularly?
  Date of last dental visit _____
- ❑ Has an orthodontist been consulted previously?
  Reason: _____

List any wind instrument played: _____

_____

Sports: _____

What would you like to have orthodontic treatment accomplish?

_____

Patient's attitude towards having orthodontics: (circle one)

WANTS IT DONE **DOES NOT WANT IT DONE** **DOES NOT CARE**

PATIENT AUTHORIZATION – PLEASE SIGN BELOW

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my information consent. Notice of Privacy Practices: I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office of Dr. Seth Senestraro, DDS, MS.

_____ _____
signature date

I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____
signature date

SENESTRARO FAMILY
ORTHODONTICS

Seth Senestraro, DDS, MS
Orthodontics & Dentofacial Orthopedics

Patient's Name: _____

Last First Middle Initial

In order to ensure quality orthodontic care it is important that both parents and patients understand the manner in which we schedule your appointments. Our goal is to be the best part of your day. We make it top priority to value both you and your time. That's why we make every effort to stay on or ahead of schedule. Most parents work and all children attend school. Inconveniencing your work schedule and interruption your child's studies as infrequently as possible is very important to our entire office. Since the vast majority of our patients are of school age, it is unavoidable that some school-time appointments will be necessary.

We understand that education is important. We will be glad to work around certain classes that are very important or ones in which your child may be having problems. We provide your child with school excuses for scheduled orthodontic appointments and it is important for your child to turn these in to the appropriate school official.

We want you to know our staff will work hard to provide the finest orthodontic care using the most convenient scheduling system possible for you and your child. We also have families and children and understand your scheduling concerns and will do everything we can to ensure your child's treatment goes as smoothly as possible.

- **LONG APPOINTMENTS, BANDING , AND BONDING:** These are more detailed and technique-sensitive appointments. Therefore, these appointments will be scheduled during our quieter morning hours.

- **COMFORTS:** As your comfort is our main concern, these are special appointments reserved for those times when a little something is poking or irritation you and simply won't do. We will get you into our schedule as soon as possible to remove the minor irritation until your next appointment.

- **EMERGENCIES:** (Pain, swelling, or bleeding) This is usually results from trauma to the face or mouth. These patients will be seen as soon as possible and appropriate care will be given or patient will be referred to another specialist for treatment.

- **REPAIRS:** (Loose bands or brackets, broken arch wires or ties, broken appliances or retainers) these appointments are always scheduled during school hours at a specific time since they are long visits. The vast majority of your appointments over the course of treatment will be short appointments. By seeing our long-visit patients during school hours, it leaves more room in our schedule to see more patients after school hours.

- **APPOINTMENTS BROKEN OR NOT CANCELLED WITHIN 48 HOURS:** Another appointment will be scheduled but may require waiting four to six weeks. An appointment during school hours may be arranged sooner.

- **GENERAL DENTIST APPOINTMENTS:** As you progress through your treatment, it is important to your oral health that you continue to see your regular dentist every six months for a check up and cleaning. When you schedule your next dental appointment, please let us know. We will schedule two coordination appointments to temporarily remove your wires pre dental visit. Immediately after your dental visit, we will replace your wires to ensure progressive tooth movement.

Thank you so very much for understanding!

I have read and agree to the scheduling information above:

Parent signature: Date:

Patient's signature: Date:

SENESTRARO FAMILY
ORTHODONTICS

Seth Senestraro, DDS, MS
Orthodontics & Dentofacial Orthopedics

At Dr. Senestraro's office we take pride in providing a fun and welcoming environment for our patients, while at the same time recognizing the need for confidentiality.

We would like to ask your permission to include you and your child in on the fun. By signing this release, you are allowing us to:

- ☐ Put the patient's photo and name on our bulletin board or web page including social media
- ☐ Display the patient's name in various ways, including the sign-in computer, signs welcoming new patients to our office
- ☐ Send recall postcards to remind the patient when it's time to come in for a follow-up visit
- ☐ Leave messages on the home or work telephone

Patient/Responsible Party Date: