



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, Nick Name, Address, City, Cell Phone Provider, Dentist, School, Today's Date, Sex, Age, Birth Date, Home Phone, Cell Phone, Email Address, Physician, Siblings/DOB

SELF OR PRIMARY GUARDIAN

Name, Address, How long at address, Main Contact #, Email Address, Social Security Number, Date of Birth, Marital Status

SPOUSE OR SECONDARY GUARDIAN

Name, Address, Main Contact #, Email Address, Social Security Number, Date of Birth, Marital Status

PRIMARY DENTAL INSURANCE ONLY

Ortho Coverage?, Insurance Co. Name, Insurance Co. Address, Insurance Co. Phone, Group #, Policy Owner's Name, ID Number, Employer, Date of Birth

SECONDARY DENTAL INSURANCE ONLY

Ortho Coverage?, Insurance Co. Name, Insurance Co. Address, Insurance Co. Phone, Group #, Policy Owner's Name, ID Number, Employer, Date of Birth

PLEASE COMPLETE OTHER SIDE SenestraroFamilyOrtho.com



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:

- | | |
|---|--|
| <input type="checkbox"/> Positive HIV Test | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Faintness/Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tonsils Removed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Adenoids Removed |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Sore Throats |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Kidney or Liver Involvement | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> 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** (select)
- Mouth-breathing when: **ASLEEP AWAKE** (select)
- 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: (select 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



Seth Senestraro, DDS, MS
Orthodontics & Dentofacial Orthopedics

SENESTRARO FAMILY
ORTHODONTICS

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: