103 ORTHODONTICS

PATIENT INFORMATION Today's Date____/____/_____

Patient's Name_____ Preferred Nickname?_____

Date of Birth ____/____/_____ Gender_____

Patient's Address_____

City_____State_____Zip_____ Home Phone (___)_____

Cell Phone (___)_____E-Mail Address_____

Patient's School_____Grade_____

Whom may we thank for referring you?_____

MOTHER'S INFORMATION Mother's Name_____ Date of Birth ____/____/____

Employer_____ Occupation_____ SS#___-___-____

Dental Insurance Company_____ Group#_____ Member's ID#_____

Mother's Mailing Address & Phone Number (if different than patient's): _____

_____

Marital Status of Responsible Party: Single___ Married___ Widowed___ Divorced___ Separated___ Other_____

FATHER'S INFORMATION Father's Name_____ Date of Birth ____/____/____

Employer_____ Occupation_____ SS#___-___-____

Dental Insurance Company_____ Group#_____ Member's ID#_____

Father's Mailing Address & Phone Number (if different than patient's): _____

_____

BRUSTEIN LISSAUER ORTHODONTICS
Scott Brustein, DDS & Jordan Lissauer, DMD
3767 Hylan Blvd, Staten Island, NY, 10308 • (718) 966-2720 • info@hylansmile.com

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REASON FOR YOUR VISIT TODAY

- Did a dentist recommend seeing an orthodontist? Yes No
- What is your main concern that brings you here today? _____
  _____
- Have you had a consultation with an orthodontist before? Yes No
  - If yes, what was the orthodontist's recommendation?_____

DENTAL INSURANCE

- Does your dental insurance cover orthodontics? Yes No Not sure
  - If yes, approximately how much? _____
- If someone else in the family recently had orthodontics, how much did the insurance cover?_____
  - And what was your out-of-pocket expense?_____

CONCERNS

- What would be your biggest concerns about starting orthodontics? Please check all that apply:
  - ❏ Discomfort
  - ❏ Finances/Fees
  - ❏ Length of orthodontics
  - ❏ Number of appointments
  - ❏ Age
  - ❏ Oral Hygiene
  - ❏ Other:_____
- *Optional:* If you circled Finances/Fees above, what would be the most that you would feel comfortable paying per month in a payment plan? We only ask so that we can help with a payment plan that works for you. Our goal is for orthodontics to be affordable for everyone on Staten Island!
  $50 $100 $150 $200 $250 $300 Other:_____

MISCELLANEOUS

- Are there any past or current oral habits? None Pacifier Thumb sucking Other_____
- Are there any sleeping issues? None Grinding Mouth breathing Snoring Bed wetting Other____
- Are there any speech concerns? Yes No (If yes, please explain:_____)
- Are there any TMJ issues? None Jaw pain Limited opening Clicking Popping Lock jaw

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PATIENT MEDICAL HISTORY

Current Dentist_____Phone_____

Medical Physician_____Phone_____

Do you have any health issues? Yes No
If so, please list: _____

Have you ever been a patient in a hospital or emergency room? Yes No
If so, what was the cause?_____

Have you ever reacted to any medicine (i.e. penicillin, aspirin)? Yes No
If so, what kind of reaction?_____

Are you allergic to anything? If yes, what?_____ Yes No

Do you have any emotional, mental or nervous concerns? Yes No

Do you bleed excessively when cut? Yes No

Please list any medications: _____

Woman Only: Do you suspect that you are pregnant? Yes No

Have you ever had any of the following diseases/medical issues?

( ) Kidney ( ) Diabetes ( ) Bleeding ( ) Asthma ( ) Liver ( ) Mitral Valve Prolapse
( ) Speech ( ) Anemia ( ) Epilepsy ( ) Sickle Cell ( ) Convulsions ( ) Heart Disease/Murmur
( ) Convulsions ( ) Hemophilia ( ) AIDS/HIV ( ) Cancer ( ) Covid 19 ( ) Rheumatic Fever
( ) Other_____

Is there anything else that we should know about you or your medical history?_____

Consent Form: I affirm that the foregoing statements are true and accurate to the best of my knowledge and understand that all disclosure of any medical problems is vital to proper dental diagnosis and treatment.

Signature_____ Date___/___/_____

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Welcome to the Brustein Lissauer Orthodontics Family!

Our orthodontic practice on Staten Island began in 1990, and we built this state of the art facility in 2003, with a primary goal of being able to provide you with a friendly, modern, and state-of-the-art orthodontic office.

Dr. Scott Brustein

I received my Bachelor's degree at The Johns Hopkins University in 1979, with Dean's List honors. I then went on to Columbia University School of Dental and Oral Surgery for my dental training, as well as my specialty in orthodontics in 1987. I am a past president of the Columbia Orthodontic Alumni Society as well as a past President of the Richmond County Dental Society. Your children may recognize me from my school visits during February Children's Dental Health Month.

Dr. Jordan Lissauer

I graduated from the University of Michigan as Co-Valedictorian and was elected to the Phi Kappa Phi Honor Society. I then went on to Tufts Dental School, again graduating as valedictorian. I continued my training at Coler-Goldwater Hospital in New York and was appointed Chief Resident, and then completed my orthodontic residency at Montefiore Medical Center and became a Board Certified Diplomate of the American Board of Orthodontics. My wife Amy and I live in NJ and have two young kids named Cole and Jack.

The extra things we do to Help Staten Island Smile!

1. We are in-network with almost all insurance plans.
2. We are amazing at Invisalign and Braces for the entire family. *Shh! We see lots of adults.*
3. We offer reasonable payment plans with no interest.
4. We offer extended evening and Saturday hours for your convenience.
5. We strive to remain on schedule!
6. We pride ourselves on having meticulously clean and sterile operatories. We have HEPA filters throughout the office and go above and beyond all OSHA and HIPPA regulations.
7. We always have an ample supply of orthodontic toothbrushes, rubber-bands, and wax.
8. You may decorate your appliance with any number of colors and designs!
9. We try to make orthodontics fun!
10. We are on-call 24 hours if you need us. The emergency number is 718-569-8503.
11. We accept cash, checks, Visa, MasterCard and ACH as forms of payment.
12. We provide text and email appointment reminders prior to appointments.
13. We offer several types of braces, from traditional metal to clear braces and Invisalign.
14. We are always available to answer any and all questions from the most basic treatment options to intricate details of the appliances used.
15. We support local businesses, restaurants, schools and everything Staten Island!

Thanks! Dr. Brustein, Dr. Jordan and the Dream Team

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PRIVACY PRACTICES AND CONSENT FORM

Acknowledgement of review of notice of privacy practices and consent for use and disclosure of health information.

To the patient - Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent ot our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healtcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Our office at 718-966-2720

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I have reviewed a copy of this office's Notice of Privacy Practices.

Signature: _____ Date:____/____/_____

Name:_____

Relationship to Patient:_____

You are entitled to a copy of this consent after you sign it.

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