



Today's Date ___/___/___

PATIENT INFORMATION

Patient's Name _____ Preferred Nickname? _____

Date of Birth ___/___/___ Gender _____ SS# ___-___-___

Patient's Address _____

City _____ State _____ Zip _____ Home Phone (___) _____

Cell Phone (___) _____ E-Mail Address _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone#(____) _____

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___ Other _____

Employer _____ Occupation _____

Dental Insurance Company _____

Member ID# _____ Group # _____

Do you have any friends or family members that come to this office? _____

SPOUSE'S INFORMATION

Name: _____ SS# ___-___-___ Date of Birth ___/___/___

Employer _____ Occupation _____

Dental Insurance Company _____

Member ID# _____ Group # _____

103 ORTHODONTICS
3767 Hylan Blvd, Staten Island, NY, 10308 • 129 Slosson Ave, Staten Island NY 10314
www.103ortho.com • (718) 966-2720 • smile@103ortho.com





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
o If yes, what was the orthodontist's recommendation?

DENTAL INSURANCE

- Does your dental insurance cover orthodontics? Yes No Not sure
o If yes, approximately how much?
• If someone else in the family recently had orthodontics, how much did the insurance cover?
o 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.

I grant approval to 103 Orthodontics to share my radiographs, photographs, orthodontic findings and recommended orthodontic treatment with my dentist, as well as approval of the dentists discussing my dental treatment.

Signature _____ Date ___/___/___

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Welcome to the 103 Orthodontics Family!

Our Staten Island orthodontic practice began in 1990. We built our Great Kills state-of-the-art facility in 2003 and our brand new North Shore office in 2026. Our mission is to provide you with the friendliest, highest quality and most technological orthodontics.

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.

Dr. Kyle Sevel

I graduated from Yale University and then completed dental school at Columbia University College of Dental Medicine. While at Columbia, I was awarded the Dr. David Whiston Leadership Award from the American Dental Association Foundation for my contributions towards improving the oral health of the public. Staying in the NYC area, I completed my orthodontic residency program at Montefiore Medical Center, earning my certificate in Orthodontics and Dentofacial Orthopedics (from the same program as Dr. Jordan!).

Some of the extra things we do to Help Staten Island Smile!

1. We are in-network with almost all insurance plans.
2. We have two locations on Staten Island (Great Kills and North Shore). You are able to be seen in either office throughout your orthodontics.
3. We are amazing at Invisalign and Braces for the entire family. *Shh! We see lots of adults.*
4. We are huge believers in early expansion at a young age if the mouth is too crowded.
5. We offer very reasonable payment plans with no interest.
6. We are a full-time orthodontic practice open 5 days per week with two orthodontists!
7. We offer extended evening and Saturday hours for your convenience.
8. We strive to remain on schedule! And we always have a supply of rubber-bands and wax.
9. We pride ourselves on having meticulously clean and sterile operatories. We go above and beyond all OSHA and HIPPA regulations.
10. We try to make orthodontics fun!
11. We are on-call 24 hours if you need us. The emergency number is 718-569-8503.
12. We accept cash, checks, Visa, MasterCard and ACH as forms of payment.
13. We provide text and email appointment reminders prior to appointments.
14. We offer several types of braces, from traditional metal to clear braces and Invisalign.
15. We are always available to answer any and all questions!
16. We support local businesses, restaurants, schools and everything Staten Island!

Thanks! Dr. Jordan, Dr. Kyle 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 to 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 healthcare 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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