

# Welcome to Mockaitis Orthodontics

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## Patient Information

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ School \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Whom may we thank for referring you to our office? \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_ Marital Status: Single Married Divorced  
First Middle Last

Address \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Previous Address (if less than 3 yrs) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
First Middle Last

Spouse's Address (if different) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Ph \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

## Dental Insurance Information

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Subscriber No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Do you have other dental insurance? Y N

## Emergency Information

Name of emergency contact \_\_\_\_\_ Phone \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ Relationship \_\_\_\_\_  
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian

## Medical History

Patient's Physician/Pediatrician Name \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

### Has your child ever had any of the following medical conditions?

Y N AIDS/HIV infection	Y N Fainting spells or seizures	Y N Rheumatic heart disease
Y N Anemia	Y N Heart attack	Y N Sexually transmitted disease
Y N Artificial heart valves	Y N Heart murmur	Y N Sinus trouble
Y N Arthritis	Y N Hemophilia/Blood disorder	Y N Speech disorder
Y N Asthma	Y N Hepatitis/Jaundice	Y N Substance abuse problem
Y N Birth Defects	Y N High blood pressure	Y N Thyroid or endocrine problems
Y N Diabetes	Y N Kidney trouble	Y N Tuberculosis
Y N Emphysema	Y N Mental disorder	Y N Tumor (Cancerous or benign)
Y N Epilepsy	Y N Nervous system disorder	Y N Trauma to face or jaw

### Is your child allergic to any of the following:

Y N Latex    Y N Penicillin or other antibiotics    Y N Sulfa drugs    Y N Local anesthetics    Y N Codeine

Other allergies \_\_\_\_\_

Does your child have any disease, condition or problem not listed above that you think we should know about?    Y N

If so, please explain \_\_\_\_\_

Has your child ever been hospitalized? Y N If yes, please give reason and date(s) \_\_\_\_\_

Does your child require pre-medication before dental visits? Y N

Is your child taking any medication (incl. non-prescription)? Y N If so, please explain \_\_\_\_\_

## Dental History

What is your chief concern regarding your child? \_\_\_\_\_

Has your child had a previous orthodontic visit? Y N Name: \_\_\_\_\_

Date of last dental exam \_\_\_\_\_

### Does your child have any of the following conditions?

Y N Chipped or injured permanent teeth	Y N Have any permanent teeth been removed?
Y N Teeth sensitive to hot or cold	Y N Have wisdom teeth been removed?
Y N Jaw fractures, cyst, mouth infections	Y N Have you been informed of missing or extra teeth?
Y N Bleeding gums or bad taste/mouth odor	Y N Clicking or popping in their jaw joint?
Y N Other periodontal (gum) problems	Y N Pain in their jaw joint?
Y N Problems with food trapped between teeth	Y N Difficulty chewing or opening your mouth?
Y N Thumb or finger habit as a child	Y N Have there been injuries to the face, mouth, or teeth?
Y N Abnormal swallowing (tongue thrust)	Y N Is all dental work completed at this time?
Y N Do you feel your child is actively growing?	Y N Males: Has there been a change in voice or facial hair?
Y N Females: Has menstruation started? If so, date _____	

Thank you. If there is any information that you feel might be of value to us in the treatment of your child, please add it below:

\_\_\_\_\_  
\_\_\_\_\_

**Office Use Only: Doctor's Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*\*I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any changes later to this history record or medical or dental status, I will inform the practice.

Signature \_\_\_\_\_ Date \_\_\_\_\_