welcome to mattiacio:)
ORTHODONTICS

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient _____ Date _____
(Last / First / Middle)

Likes to be called _____ Male ☐ Female ☐ | Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Partnered ☐

Address _____
(Street / City / Zip)

Birth date _____ Social Security # _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Birth Date _____

Spouse's Employer _____ Spouse's Occupation _____ Work Phone _____

Whom may we thank for referring you to our office? _____ General Dentist _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security _____

Insured's Birth Date _____ Relationship to Patient _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____
(Street / City / Zip)

Employer _____ Insurance Phone No. _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Social Security _____

Insured's Birth Date _____ Relationship to Patient _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____
(Street / City / Zip)

Employer _____ Insurance Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____ Phone _____
(Street / City / Zip)

MEDICAL HISTORY

Do you have a personal physician? Yes ☐ No ☐

Physician's Name _____ Phone # _____

Date of Last Visit _____ How is your current physical health? Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes ☐ No ☐ If yes, please explain: _____

Please list all prescription/over-the-counter drugs you are taking: _____

_____

For women: Are you taking birth control pills? Yes ☐ No ☐
Are you pregnant or nursing? Yes ☐ No ☐

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Anemia
Y N AIDS/HIV+
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy /Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Heart Attack/Stroke
Y N Heart Surgery/Pacemaker
Y N Hospitalized for Any Reason
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N Any Metals/Plastics
Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythomycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: _____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____

How is your current dental health? Good ☐ Fair ☐ Poor ☐
Do you like your smile? Yes ☐ No ☐
Have you ever been evaluated or had orthodontic treatment before? Yes ☐ No ☐
Have you ever had a serious/difficult problem associated with any dental work? Yes ☐ No ☐
Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ/TMD)? Yes ☐ No ☐
Do your gums ever bleed? Yes ☐ No ☐
Do you have any missing or extra permanent teeth? Yes ☐ No ☐
Have you ever had an injury to your: Mouth ☐ Teeth ☐ Chin ☐
Do you have any speech problems? Yes ☐ No ☐
Do you generally breathe through your mouth? Yes ☐ No ☐
If yes, while awake? ☐ While asleep? ☐
Have you ever taken Phen-Fen? (also known as Redux or Pondimin) Yes ☐ No ☐
If yes, when? _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information 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 that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

AUTHORIZATION

This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

_____
Initials Date

DOCTOR'S COMMENTS

_____
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