Orthodontics
Mark A. Paciorek, D.D.S., M.S., P.C.

A B C

PATIENT INFORMATION

Date____________________

Patient____Likes to be called ____________________
Last First Middle

Address ____ Male _ Female _
Street City State/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_____________________________ 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 D.O.B.________

Insurance Company____ Group No.__________Local No. ___________

Employer ____ Insurance Phone No. ____________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name___________________________Insured's Social Security #____________________ Insured's D.O.B.________

Insurance Company____ Group No.____________________________

Employer ____Insurance Phone No.____________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Complete address ____
Street City Zip Phone Number

MEDICAL HISTORY

Do you have a personal physician? ___ Yes ___ No

Physician's Name: ____ Phone #: ____________________________

Date of Last Visit: __________________________ Your current physical health: _____ Good _____ Fair _____ Poor

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

Are you taking any prescription/over-the-counter drugs? Please list each one. ____________________________________

____

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

Over

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

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

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

____

Are you allergic to any of the following?

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

Your current dental health is: ___ Good ___ Fair ___ Poor

Do you like your smile?	Y N
Have you ever been evaluated or had orthodontic treatment before?	Y N
Have you ever had a serious/difficult problem associated with any dental work?	Y N
Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ/TMD)?	Y N
Gums ever bleed?	Y N
Do you have any missing or extra permanent teeth?	Y N

Have you ever had an injury to your: ___ Mouth ___ Teeth ___ Chin

Do you have any speech problems? ______________________

Do you generally breathe through your mouth? _______ If yes, while awake? _____ While asleep? _____

Have you ever taken Phen-Fen? (also known as Redux or Pondimin) Y N 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