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

A B C

PATIENT INFORMATION

Date_____

Patient's name _____ Likes to be called _____
Last First Middle

Address_____
Street City State/Zip

Home Phone_____ Birth date_____ Child's Sex : Male or Female

Child's School _____ Hobbies/Likes _____Email Address:_____

Siblings or friends that are patients of Dr. Paciorek's already:_____

RESPONSIBLE PARTY INFORMATION

Father_ Step Father_ Guardian_ Married _ Divorced _ Single _ Widowed_

_____
Last First Middle

Mailing Address (_same as child) _____
Street City State/Zip

Home phone_____ Work phone_____ Cell phone _____

Birth date_____ Social Security #_____Email Address: _____

Employer_____ Occupation_____ No. years employed_____

Spouse (if remarried) _____Spouse's Birth Date _____

Mother_ Step Mother_ Guardian_ Married _ Divorced _ Single _ Widowed_

_____
Last First Middle

Mailing Address (_same as child) _____
Street City State/Zip

Home phone_____ Work phone_____ Cell phone _____

Birth date_____ Social Security #_____Email Address: _____

Employer_____ Occupation_____ No. years employed _____

Spouse (if remarried) _____Spouse's Birth Date _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____Birth Date _____

Insurance Company_____ Group No._____

Insurance Co. Address_____ Phone No._____

Relationship to Patient _____ Employer _____

For dual coverage complete below:

Secondary Insured's Name _____Social Security #_____Birth Date _____

Insurance Company_____ Group No._____

Insurance Co. Address_____ Phone No._____

Relationship to Patient _____ Employer _____

Over

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip Phone Number

DENTAL AND MEDICAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____
Has your child ever been evaluated or had **ORTHODONTIC** treatment before? ___ Yes ___ No
Does the child require antibiotics before dental treatment? ___ Yes ___ No
Have adenoids or tonsils been removed? ___ Yes ___ No
Does your child have any missing or extra permanent teeth? ___ Yes ___ No
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ___ Yes ___ No
Does the child brush his/her teeth daily? ___ Yes ___ No
Floss his/her teeth daily? ___ Yes ___ No

Child's Dentist: _____ Phone #: _____Last Visit: _____

Is the child currently under the care of a physician? ___ Yes ___ No Physician: _____
Has puberty begun? ___ Yes ___ No
Has menstruation begun? ___ Yes ___ No
Please describe the child's current physical health: ___ Good ___ Fair ___ Poor
Please list all drugs that the child is currently taking: _____
Aside from items listed below, list all drugs/things your child is allergic to: _____
Latex: ___ Yes ___ No Nickel/Metals: ___ Yes ___ No Plastic: ___ Yes ___ No

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes	Y	N	Kidney Problems
Y	N	ADD/ADHD	Y	N	Epilepsy	Y	N	Liver Problems
Y	N	AIDS/HIV+	Y	N	Handicaps/Disabilities	Y	N	Mitral Valve Prolapse
Y	N	Artificial Bones/Joints/Valves	Y	N	Hearing Impairment	Y	N	Prosthetics
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Rheumatic Fever
Y	N	Cancer	Y	N	Hemophilia	Y	N	Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Hepatitis	Y	N	Sickle Cell Disease/Traits
Y	N	Convulsions	Y	N	Hospital Stays/Operations	Y	N	Tuberculosis (TB)

Has the child ever taken any diet pills such as Phen-Fen (aka Redux or Pondimin? ___ Yes ___ No If so, when? _____
Are the child's immunizations current? ___ Yes ___ No
Anything you would like to discuss with the Doctor in private? ___ Yes ___ No
Does/did the child have any of the following habits?

Y	N	Nursing/Bottle Habits	Y	N	Nail Biting	Y	N	Tongue Thrust
Y	N	Clenching/Grinding Teeth	Y	N	Used Pacifier	Y	N	Mouth Breather
Y	N	Lip Sucking/Biting	Y	N	Thumb/Finger Sucking	Y	N	Speech Problems

List any musical instruments played: _____

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 of Parent or Guardian Date

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 is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

_____
Signature of Parent or Guardian Date