Welcome to Mockaitis Orthodontics

Reed P. Mockaitis DDS, MS, PA

Patient Information

Patient's Name _____ Preferred Name _____
First Middle Last

Address _____
Street City State Zip

Birthdate _____ Sex _____ Age _____

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

Responsible Party Information

Name _____ Marital Status _____
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 of Patient _____ Date _____

Medical History

Patient's Physician/Pediatrician Name _____

Date of last physical exam _____

Have you ever had any of the following medical conditions?

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

Are you 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 _____

Do you have any disease, condition or problem not listed above that you think we should know about? Y N
If so, please explain_____

Have you ever been hospitalized? Y N If yes, please give reason and date(s) _____

Do you require pre-medication before dental visits? Y N

Are you taking any medication (drugs) (incl. non-prescription)? Y N If so, please explain_____

Dental History

What is your chief concern? _____

Has an orthodontist been visited previously? Y N Name: _____

Date of last dental exam_____

Do you have any of the following conditions?

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

Thank you. If there is any information that you feel might be of value to us during your treatment, 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 of Patient _____ Date _____