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 _____ 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 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

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 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 Do you feel your child is actively growing?
Y N Females: Has menstruation started? If so, date _____
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?
Y N Males: Has there been a change in voice or facial hair?

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 are any changes later to this history record or medical or dental status, I will inform the practice.

Signature _____ Date _____
Parent or Guardian