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:

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Office Use Only: Doctor's Comments: ____________________

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**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 ____________________