

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 Fainting spells or seizures | Y N Rheumatic heart disease |
| Y N Anemia | Y N Heart attack | Y N Sexually transmitted disease |
| Y N Artificial heart valves | Y N Heart murmur | Y N Sinus trouble |
| Y N Arthritis | Y N Hemophilia/Blood disorder | Y N Speech disorder |
| Y N Asthma | Y N Hepatitis/Jaundice | Y N Substance abuse problem |
| Y N Birth Defects | Y N High blood pressure | Y N Thyroid or endocrine problems |
| Y N Diabetes | Y N Kidney trouble | Y N Tuberculosis |
| Y N Emphysema | Y N Mental disorder | Y N Tumor (Cancerous or benign) |
| Y N Epilepsy | Y N Nervous system disorder | 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 Have any permanent teeth been removed? |
| Y N Teeth sensitive to hot or cold | Y N Have wisdom teeth been removed? |
| Y N Jaw fractures, cyst, mouth infections | Y N Have you been informed of missing or extra teeth? |
| Y N Bleeding gums or bad taste/mouth odor | Y N Clicking or popping in their jaw joint? |
| Y N Other periodontal (gum) problems | Y N Pain in their jaw joint? |
| Y N Problems with food trapped between teeth | Y N Difficulty chewing or opening your mouth? |
| Y N Thumb or finger habit as a child | Y N Have there been injuries to the face, mouth, or teeth? |
| Y N Abnormal swallowing (tongue thrust) | Y N Is all dental work completed at this time? |
| Y N Do you feel your child is actively growing? | Y N Males: Has there been a change in voice or facial hair? |
| Y N Females: Has menstruation started? If so, date _____ | |

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