PATRITTO ORTHODONTICS

What is the reason for your visit?

PATIENT INFORMATION

Patient Name _____ General Dentist _____ Physician _____

How Did You Hear About Our Office? Please Check Any That Apply: General Dentist _____ Patient Referral _____

Web Site _____ Newspaper _____ Yellow Pages _____ TV _____ Other _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Birthdate _____

EMPLOYER INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Occupation _____

DENTAL INSURANCE COMPANY

Policyholder: Self _____ Spouse _____ Other _____

Name of Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Insurance Phone _____ ext. _____

Insurance ID# _____

Group ID# _____

Social Security Number _____
(For Insurance Purposes Only)

Must be filled out completely in order to bill insurance company

SPOUSE INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Birthdate _____

EMPLOYER INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Occupation _____

DENTAL INSURANCE COMPANY

Policyholder: Self _____ Spouse _____ Other _____

Name of Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Insurance Phone _____ ext. _____

Insurance ID# _____

Group ID# _____

Social Security Number _____
(For Insurance Purposes Only)

Please Provide Your Insurance Card For Any Insurance Billing

Dwayne J. Patritto, DDS, MS, PLC

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(641) 673-4120
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MEDICAL HISTORY

Is the patient in good health? Yes/No Has the patient had a physical this year? Yes/No

Is the patient under the care of a physician? Yes/No If so, explain _____

Presently taking any medication? Yes/No If so, please list _____

Is the patient allergic to anything? Yes/No If so please list _____

Does the patient need to be premedicated with antibiotics for Dental appointments? _____

Does the patient have a history of heart murmur or rheumatic fever? _____

Is the patient pregnant? Yes/No Does the patient have a drug addiction? Yes/No Does the patient smoke? Yes/No

Does the patient have any history of: (please circle)

AIDS/HIV	Cancer/Tumors	Gastrointestinal Disorders	Kidney Disease	Scarlet fever
Anemia	Diabetes	Heart Disease	Liver Disease	Tuberculosis
Arthritis	Endocrine Disorders	Hemophilia	Nervous Disorders	Yellow Fever
Asthma	Epilepsy	Hepatitis	Prolonged Bleeding	Venereal Disease
Blood Disease	Fainting	High Blood Pressure	Respiratory Disease	Cold Sores

Are you aware of any other diseases, conditions or problems not listed above that we should know about? If yes, what?

DENTAL HISTORY

Approximate date of last dental visit? _____Has the patient been examined by an orthodontist before? Yes/No

Does the patient experience any pain, clicking or discomfort in or near the ears or jaw joints? Yes/No

Has the patient's mouth, face or teeth been injured by a fall or accident? Yes/No

Has the patient ever been informed of missing or extra permanent teeth? Yes/No

Has the patient had any permanent teeth removed? Yes/No

Is the patient aware of any gum problems? Yes/No

Has the patient's tonsils or adenoids been removed? Yes/No

Does the patient have or ever had any of the following habits? (please circle)

Cheek, Tongue or Lip Chewing	Mouth Breathing	Clenching Teeth	Grinding Teeth
Thumb/Finger Sucking	Finger Nail Biting	Tongue Thrusting	Speech Problems

Have any other family members had treatment done by Dr. Patritto? Yes/No

Name/Ages

Signature_____ **Date** _____