***JOHN J. MARCHETTO, D.M.D.***
***MARISSA N. COOPER, D.M.D, MS***

Specialist in Orthodontics
Children n Teenagers n Adults

*We would like to welcome you to our office. Our goal is to make every patient's visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.*

## Personal Information

Today's Date: _____

Name: _____

Title: Mr. Mrs. Ms. Miss Dr. Other _____

Birthdate:_____/_____/_____ Age_____ Sex_____

Address: _____
Apt/Condo#

_____
City State Zip

Home_____Cell._____Wk_____

Email:_____

Hobbies/Interests:_____

Employer: _____

Occupation _____

Spouse's Name: _____

Employer: _____

Occupation: _____

Business Phone: (_____)_____

*General Dentist*: _____

_____
City State

Date of Last Visit: _____

*Whom may we thank for referring you?*
_____

Name and Address of person responsible for account:

Name_____

Billing Address_____

_____
City State Zip

Phone: (_____) _____

## Primary Orthodontic Insurance

Orthodontic Coverage? Yes____No____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone :(_____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Insured's Date of Birth:_____ID#_____

Relationship to Patient:_____

Insured's
Employer:_____

## Secondary Orthodontic Insurance

Orthodontic Coverage? Yes____No____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone :(_____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Insured's Date of Birth:_____ID#_____

Relationship to Patient:_____

Insured's
Employer:_____

## Dental History

Has patient ever had previous orthodontic treatment?_____
Has any other family members been treated in this office?___
Please name them _____
Has patient ever been treated for gum disease?_____
Has the patient: (Please circle Y or N)

| | | |
|---|---|---|
| 1. Had any injuries to the face, head or neck? | Y | N |
| 2. Received a severe blow to the teeth or jaw? | Y | N |
| 3. Had difficulty chewing or swallowing food? | Y | N |
| 4 .Had bleeding or infection of the gums? | Y | N |
| 5. Have you ever sucked a finger? (until what age_____) | Y | N |
| 6. Had permanent teeth removed? | Y | N |
| 7. Experienced frequent headaches? | Y | N |
| 8. Had pain in face, neck or shoulder region? | Y | N |
| 9. Had pain or popping of the jaw joint (T.M.J.)? | Y | N |
| 10. Had difficulty in opening or closing the jaw? | Y | N |
| 11. Does the patient clench or grind the teeth? | Y | N |
| 12. Do the jaws get tired during a meal? | Y | N |
| 13. Had any unusual dental problems? | Y | N |
| 14. Had any adverse reaction to latex? | Y | N |
| 15. Had any adverse reaction to local anesthetics? | Y | N |

You are interested in orthodontic treatment for:

____Improved Appearance
____Improved Function
____Relief and Comfort
____Improved Oral Health
____Improved speech
____Other, Explain:
_____

How did you first become aware of your need for orthodontic treatment?_____
How did you select our office?_____
Have you ever had an orthodontic consultation or treatment before now? _____

## Medical History

Name of Patient's Physician:_____

_____
City State

(Please circle Y or N)
Are you currently under the care of a physician? Y N
If yes, please explain:_____
Are you presently taking any medications? Y N
If yes, please list_____
Taken for:_____
List any medications, food, pollens, or other elements you may be allergic to:_____
Are you currently or trying to become pregnant? Y N
Is there anything else that the doctor should know about your health?_____

Do you take antibiotic pre-medication before any dental procedures? _____
Do you chew or smoke tobacco?_____
Have you noticed any changes in your face or jaws? ___

Have you ever experienced any of the following medical problems?

Please circle:

| | |
|---|---|
| Adenoids Removed | Hepatitis |
| AIDS/HIV | Herpes |
| Anemia | History of Bulimia or Anorexia |
| Arthritis | Infectious Disease |
| Asthma | Intestinal Disorder |
| Canker Sores | Kidney Stones |
| Diabetes | Nervous Disorders |
| Drug/Alcohol Dependency | Prolonged bleeding |
| | Rheumatic Fever |
| Epilepsy/seizures | Speech/Hearing Problem |
| Frequent Colds | Tonsils Removed |
| Heart Disease | Tuberculosis |
| Heart Murmur(MVP) | Osteoporosis |
| High or Low BP | Thyroid Problems |

I understand that the information which I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need.

_____
Signature of Patient Date