Welcome to Mongiovi Orthodontics

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

Tell us about yourself

Date: ____/____/____ ☐ Male ☐ Female

Name:____

I prefer to be called:____________________ Age:__________

Date of Birth: ____/____/____ SSN: ______-______-________

Home Address:____

____

Email:____

Home #: __________________ Work #: ________________

Cell #: ____________ Text?: ☐ Y or ☐ N Provider:__________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

****

Who may we thank for referring you?: _____________________

Other family members seen by us: ________________________

General Dentist: ______________________________________

Located in:____________________ Last visit: ____/____/____

Employer Information

Employer: ____

Address: ____

Occupation: _________________ How long there?: ________

Spouse Information

Name: ___________________ Date of Birth: ____/____/____

Address (if different from patients):______________________

____

Employer: _______________________ Title:_______________

Employer Address: ______________________________________

Work #: ___________________ Cell #: __________________

How long at current job?:_____ SSN: ______-______-________

In case of an emergency, whom do we contact?

Name:____

Relation: __________________ Phone #: _________________

Responsible Party: (Leave blank if you are the responsible party) Please designate one person who will take responsibility for scheduling visits, financial obligations, and insurance coverage, and will also participate in home care instructions.

Name:____

Relation:____

Address (if different from patients):_______________________

____

Home Phone:____

Work Phone:____

Cell Phone:____

Email:____

Insurance Information

Primary Insurance: **Dental Coverage?** ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ___________________________________

Insurance Co. Address:_________________________________

____

Phone #: __________________ Group #: ________________

Policy Owner Name: ____________________________________

Date of Birth: ____/____/____ SSN: ______-______-________

Is there any secondary Insurance? If so, please note information below:

____

____

____

____

____

____

Continued on next page

Medical History

Your General Health: ☐ Good ☐ Fair ☐ Poor

Name of Physician:____

Date of last visit: ____ /____ /____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____________________________________

____

Please list all medications you are currently taking:___________

____

Please list any drug or non-drug allergies: __________________

____

Are you allergic to any of the following? (please check)

☐ Metals ☐ Plastics ☐ Latex ☐ Penicillin ☐ Antibiotics

☐ Dental Anesthetics ☐ Other:__________________________

Dental History

- Have you ever been evaluated or had orthodontic treatment before?: ☐ Yes ☐ No
- Have there been any injuries to the face, mouth, teeth or chin?: ☐ Yes ☐ No
- Have you been informed of any missing or extra permanent teeth?: ☐ Yes ☐ No
- Do you have any pain or tenderness in the jaw joint (TMJ/TMD)?: ☐ Yes ☐ No
- Do you have any speech problems?: ☐ Yes ☐ No
- Do you currently have a thumb or finger sucking habit?: ☐ Yes ☐ No
- What are the main concerns you would like orthodontics to accomplish?: __________________

  ____

Please check Yes ('Y') or No ('N') whether you have a history of the following:

☐ Y	☐ N	Abnormal bleeding	☐ Y	☐ N	Handicaps/Disabilities	☐ Y	☐ N	Venereal Disease
☐ Y	☐ N	ADD/ADHD	☐ Y	☐ N	Heart Attack	☐ Y	☐ N	Epilepsy/Seizures
☐ Y	☐ N	Anemia	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Mitral Valve Prolapse
☐ Y	☐ N	Arthritis	☐ Y	☐ N	Heart Surgery/Pacemaker	☐ Y	☐ N	Ever been hospitalized?
☐ Y	☐ N	Artificial Bones/Joints	☐ Y	☐ N	Hepatitis			
☐ Y	☐ N	Asthma/Diff. breathing	☐ Y	☐ N	High/Low Blood Pressure			
☐ Y	☐ N	Back Problems	☐ Y	☐ N	HIV+/AIDS			
☐ Y	☐ N	Blood Disease	☐ Y	☐ N	Kidney/Liver Problems			
☐ Y	☐ N	Blood Transfusion	☐ Y	☐ N	Psychiatric Problem			
☐ Y	☐ N	Cancer/Chemotherapy	☐ Y	☐ N	Rheumatic/Scarlet Fever			
☐ Y	☐ N	Congenital Heart Defect	☐ Y	☐ N	Severe/Frequent Headaches			
☐ Y	☐ N	Diabetes	☐ Y	☐ N	Shingles			
☐ Y	☐ N	Drug/Alcohol Abuse	☐ Y	☐ N	Sickle Cell Disease/Trait			
☐ Y	☐ N	Emphysema	☐ Y	☐ N	Sinus Problems			
☐ Y	☐ N	Fainting Spells	☐ Y	☐ N	Thyroid Disease/Malfunc.			
☐ Y	☐ N	Fever Blisters/Herpes	☐ Y	☐ N	Tonsils/Adenoids Removed			
☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Tuberculosis			

Please provide additional information if you checked YES to any of the above:

____

____

____

____

____

____

____

____

____

____

I understand that the information that I have given is correct, to the best of my knowledge, and that it will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in the patient's medical status. A copy of the office's HIPPA policy is posted and I understand my rights and the office's procedures as stated in the policy. A personal copy is available upon my request. During today's visit, and subsequent Recall visits, I understand that the Doctor will provide Orthodontic treatment recommendations. I understand that there are risks associated with any Orthodontic treatment plan. I understand that I am always welcome to review the treatment recommendations with the Doctor and to voice any concerns that I may have.

I hereby consent to the making of diagnostic records, including x-rays and give consent to the Doctor and his staff to provide orthodontic treatment prescribed by the Doctor for the patient. I hereby authorize the Doctor to provide other health care providers with information regarding the patient as deemed appropriate. I understand that once released, the Doctor and his staff have no responsibility for any further release by the individual receiving this information.

Patient Signature:____ Date: ____ /____ /____

OFFICE USE ONLY

Doctor's Comments: ____

Doctor's Signature: ____ Date: ____ /____ /____