MATTESON ORTHODONTICS

Specialist in Orthodontics

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

ABOUT YOU

Date: _____ FirstName: _____ Last_____

SS#: _____ Nickname: _____

Birthdate: ____/____/_____ Age____ □ Male □ Female

Home address: _____

City: _____ State: _____ Zip: _____
Home phone #: (_____) _____-_____
Work phone #: (_____) _____-_____ Ext: ____

□ Single □ Widowed □ Married □ Divorced □ Separated

Employer: _____
Employer's address _____

# of years employed _____ Occupation _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General dentist: _____

Last visit date: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
Billing address: _____

City: _____ State: _____ Zip: _____

Work Phone#: (_____) _____- _____ Ext: _____

Employer: _____

SS# _____-_____-_____ DL# _____

# of years employed: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their name: _____

Home phone #: (_____) _____-_____

Work phone #: (_____) _____-_____ Ext: ____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: □ Yes □ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. phone#: (_____) _____-_____

Group# (plan, local, or policy#): _____

Insured's Name: _____ Relation: _____

Insured's birthdate: _____/_____/_____

SS# or ID: _____

Insured's employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage: □ Yes □ No

Insurance Co. Name: _____

Insurance Co. phone#: (_____) _____-_____

Group# (plan, local, or policy#): _____

Insured's Name: _____ Relation: _____

Insured's birthdate: _____/_____/_____

SS# or ID: _____

Insured's employer: _____

SPOUSE INFORMATION

Name: _____
Work Phone#: (_____) _____-_____ Ext:_____
Home Phone#: (_____) _____-_____
Employer: _____
SS#: _____-_____-_____ DL# _____

E-MAIL ADDRESS

Name:_____
E-mail Address: _____

FORM CONTINUED ON BACK

4440 W. Lincoln Hwy Suite 300 ● Matteson, IL 60443 ● Phone (708) 481-6086 ● Fax (708) 481-2525

MEDICAL HISTORY

Your current physical health: □ Good □ Fair □ Poor
Are you currently under the care of a physician?
Please explain: _____
Are you taking any prescription/over-the-counter drugs?
Please list each one: _____
_____

Y N	Heart attack/stroke	Y N	Psychiatric problems
Y N	Cancer/chemotherapy	Y N	Epilepsy/seizures/fainting
Y N	Heart murmur	Y N	Diabetes
Y N	Rheumatic fever	Y N	Drug/alcohol abuse
Y N	HIV+/AIDS	Y N	Tuberculosis (TB)
Y N	Heart surgery/pacemaker	Y N	Hemophilia/abnormal bleeding
Y N	Shingles	Y N	Ulcers/colitis
Y N	Mitral valve prolapse	Y N	Congenital heart defect
Y N	Kidney problems	Y N	Anemia/radiation treatment
Y N	Artificial bones/joints	Y N	Asthma/arthritis
Y N	Artificial valves	Y N	Difficulty breathing
Y N	Sinus problems	Y N	Hospitalized for any reason
Y N	High/low blood pressure	Y N	Hepatitis
Y N	Fever blisters	Y N	Blood transfusion
Y N	Severe/frequent headaches	Y N	Emphysema/glaucoma
Y N	Wears contact lenses	Y N	Glaucoma/eye problems
Y N	Thyroid disease	Y N	Chronic cough

Please list any medical condition(s) that you have ever had:
_____

Are you allergic to any of the following items?

Y N	Penicillin	Y N	Tetracycline	Y N	Latex
Y N	Aspirin	Y N	Dental anesthetics	Y N	Codeine
Y N	Erythromycin	Y N	Tetracycline	Y N	Latex

Please list any other drugs that you are allergic to: _____
_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____
_____
_____

Have you ever had or been evaluated for orthodontic treatment? □ Yes □ No

Have you had a serious/difficult problem associated with any previous dental work? □ Yes □ No

Do you now or have you ever experienced pain discomfort your jaw joint (TMJ/TMD)? □ Yes □ No

Your current dental health is: □ Good □ Fair □ Poor

Do you like your smile? □ Yes □ No
Do your gums bleed? □ Yes □ No
Have you ever had an injury to your: Mouth Teeth Chin
Please Circle One

Do you have any speech problems? _____
_____

Do you generally breathe through your mouth?
While awake □ Yes □ No Sleeping □ Yes □ No

Do you have any missing or extra permanent teeth?
□ Yes □ No

I understand that the information that 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 this office of any changes in my medical status.
I authorize the dental staff to perform the necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____
Signature Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____
Signature Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein, initials_____ Date _____
Doctor's comments: _____