PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date _____

Patient's Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *Zip*

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____

Patient: _____ Responsible Party: _____
Email Address *Email Address*

RESPONSIBLE PARTY INFORMATION

Name _____
Last *First* *Middle* *Marital Status*

Residence _____
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street *City* *State* *Zip*

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last *First* *Middle*

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue: _____
Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____
I understand that where appropriate, credit bureau reports may be obtained.

Dr. Cucalon's Medical & Dental History Form

Thank you for filling out this form completely! The information you provide will help us in customizing your treatment. You may be assured that Dr. Cucalon and his staff all pledge to hold the information in the strictest of confidence. For your safety, Dr. Cucalon is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Please read the paragraph below and then sign where indicated.

I understand that the information provided on this form is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I also recognize that Dr. Cucalon reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Patient/Parent Signature _____ Date _____

MEDICAL HISTORY

Do you have a personal physician? ☐ **No** ☐ **Yes**

Physician's name:_____

Phone#:_____ **Date of last visit:**_____

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

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

Please explain:_____

Are you taking any prescription/over the counter drugs: ☐**No** ☐ **Yes**

Please list each one:_____

Have you ever had any of the following diseases or medical problems?

Y	N	Heart Attack/Stroke	Y	N	Psychiatric Problems
Y	N	Cancer / Chemotherapy	Y	N	Heart Murmur
Y	N	Epilepsy/Seizures/Fainting	Y	N	Diabetes / Tuberculosis
Y	N	Rheumatic Fever	Y	N	Drug/Alcohol Abuse
Y	N	HIV+/AIDS	Y	N	Venereal Disease
Y	N	Heart Surgery/Pacemaker	Y	N	Shingles
Y	N	Hemophilia/Abnormal ding	Y	N	Ulcers/Colitis
Y	N	Mitral Valve Problems	Y	N	Congenital Heart Defect
Y	N	Kidney Problems	Y	N	Anemia/ Radiation Treatment
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 Headache	Y	N	Emphysema/Glaucoma

Please list any medical conditions that you have ever had:_____

_____

Are you allergic to any of the following items:

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Dental Anesthetics
Y	N	Aspirin	Y	N	Erythromycin	Y	N	Latex
Y	N	Any Metal/Plastic	Y	N	Codeine	Y	N	Other

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

_____

DENTAL HISTORY

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

_____

_____

_____

Have you ever had/been evaluated for orthodontic treatment? ☐ **No** ☐ **Yes**

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

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

Your current dental health is ☐ **Good** ☐ **Fair** ☐ **Poor**

Do you like your smile? ☐ **No** ☐ **Yes**

Do your gums ever bleed? ☐ **No** ☐ **Yes**

Have you ever had an injury to your (circle): Mouth Teeth Chin

Do you have any speech problems?_____

Do you generally breathe through your mouth AWAKE? ☐ **No** ☐ **Yes**

Do you generally breathe through your mouth ASLEEP? ☐ **No** ☐ **Yes**

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

Thank you for completing this form.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient/ parent named herein, Initials: _____ Date:_____

Doctor Comments:_____

_____

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