No:_____

GARY THOMAS PUCCIO, D.D.S.
BOARD CERTIFIED SPECIALIST IN ORTHODONTICS

PATIENT INFORMATION

Today's Date_____

Name_____ Sex_____ Birthdate _____/_____/_____Age_____
First M.I. Last

Address_____ Physician_____

City_____ State _____Zip_____ Dentist_____

Home Phone (___)_____ Is the patient adopted (circle): Yes No

School Attended_____Grade_____

Name/Ages of Siblings_____

Family members or friends treated here _____

Who referred you to our office_____

RESPONSIBLE PARTY INFORMATION

Please provide information about the parties who are legally and financially responsible for any care the patient may receive at this office.

Mother's Name_____Birthdate_____/_____/_____
First M.I. Last

Patient is my ☐ Biological ☐ Step ☐ Adopted ☐ Guardian Child Social Security # _____

Address (if different from above)_____

City_____State_____Zip_____Home Phone (_____)_____

E-mail address _____Cell Phone (_____)_____

Occupation_____ Employer_____ Work Phone (_____)_____

Mother's Dental Insurance Company_____ Subscriber ID #_____

Father's Name_____ Birthdate _____/_____/_____
First M.I. Last

Patient is my ☐ Biological ☐ Step ☐ Adopted ☐ Guardian Child Social Security # _____

Address (if different from above) _____

City_____State_____Zip_____Home Phone (_____)_____

E-mail address _____Cell Phone (_____)_____

Occupation_____ Employer_____ Work Phone (_____)_____

Father's Dental Insurance Company_____ Subscriber ID#_____

Parents are (circle one): Single	Partnered	Married	Separated	Divorced	Widowed
Patient lives with (circle one):	Parents	Mother	Father	Stepparent	Grandparent

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Who will be responsible for paying this account? _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

No:_____

MEDICAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions about the patient's health.

1.) Is the patient presently in good health?……..Yes No Last physical exam:_____

2.) Any change in general health within the past year?……No Yes If so, explain:_____

_____

_____

3.) Is the patient presently being treated by a physician?……..No Yes If so, what condition is (are) being treated?:_____

_____

_____

Name of treating physician(s):_____

4.) Please explain any history of serious illness, operations, hospitalizations, or emergency room visits:_____

_____

_____

5.) What medicines, if any, are presently being taken and **why**? (please include any non-prescription medications):_____

_____

_____

6.) Does the patient need to take antibiotics prior to dental appointments?…….No Yes

7.) Please circle any of the following diseases or conditions that apply to the patient:

*Heart murmur	*Rheumatic heart disease	*Artificial heart valve	*Diabetes	*Hepatitis
*ADHD/ADD	*Cardiovascular disease	*Asthma	*Lung disease	*Liver disease
*Kidney trouble	*Thyroid problems	*Aids or HIV	*Anemia	*Abnormal bleeding
*Cancer	*Neurological disease	*Tuberculosis	*Seizures	*Psychological problems

8.) Any allergy or reaction to any of the following (circle):

*Local anesthetics	*Penicillin	*Food Allergies	*Latex	*Seasonal allergies
*Aspirin	*Nickel	*Phenylephrine	*P-aminobenzoic Acid (PABA)	

*Other_____

9.) Please explain any disease, condition, or problem not listed above that you think I should know about:_____

_____

_____

FEMALES

10.) Is the patient pregnant? …..No Yes Nursing?…..No Yes Taking birth control pills?….Yes No

No:_____

DENTAL HISTORY

1.) Last dental exam:_____ Is treatment complete?……Yes No _____

2.) Have panoramic (or full mouth) x-rays been taken?……. No Yes If so, when?_____

3.) Any injuries to the face, mouth or teeth?……. No Yes _____

4.) Any finger or thumb sucking?……...No Yes Until what age?_____

4

5.) Any oral habits, lip biting, tongue thrusting?……..…..No Yes _____

6.) Has patient reached puberty?……..……..No Yes _____

7.) Are height and weight normal for age?…… Yes No Describe:_____

8.) Any missing or extra permanent teeth?…….No Yes _____

9.) Have wisdom teeth been extracted?……..No Yes If so, when?_____

10.) Any periodontal (gum) treatment?……No Yes If so, when?_____

11.) Headaches more than once a week?……..No Yes _____

12.) Any noise (clicking) or pain in jaw joints?…….. No Yes _____

13.) Any tooth grinding or jaw clenching?……...No Yes _____

14.) Have other family members had orthodontic treatment?……..No Yes If yes, who?_____

15.) Has an orthodontist been consulted previously?……...No Yes Doctor's name_____

If your dentist recommended you consult an orthodontist, what was he/she concerned about?_____

_____

What are you concerned about (circle all that apply):

*Crooked teeth *Bite problem *Misaligned jaws *Facial imbalance *Second opinion
*Other_____

What would you like to achieve with orthodontic treatment (circle all that apply):

*Straighter teeth *Bite correction *Jaw correction *Better facial appearance *Transfer of care to this office
*Other_____

I have read and understand the above inquiries. I acknowledge that my questions, if any, about the inquiries above, have been answered to my satisfaction. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this orthodontic practice.

_____ _____ _____
Signature Relationship to patient Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received and reviewed a copy of Dr. Gary T. Puccio's Notice of Privacy Practices.

_____ _____

Name Relationship to Patient

_____ _____

Signature Date

For Office Use:

Patient Name: _____ No: _____

Effective Date: September 15, 2013