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PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____ Preferred: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Birthdate: _____ Social Security Number: _____ Sex: M F

Name of Parent or Guardian: _____ Patient Lives With: Both Parents Mother Father Guardian

Has any other family member been treated at our office? If yes, who? _____

Whom may we thank for referring you to our office (your dentist or a patient/parent)? _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ Middle: _____ Birthdate: _____

Marital Status: Single Married Separated Divorced Widowed Social Security Number: _____

Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

How Long at this Address? _____ Home/Cell Phone: _____ Work Phone: _____

Relationship to Patient: _____ Employer: _____ Occupation: _____

No. Years Employed: _____ E-mail Address: _____ Appointment reminders via e-mail? Yes No

Spouse's Last Name: _____ Spouse's First Name: _____ Middle: _____

Spouse's Social Security Number: _____ Spouse's Birthdate: _____ Work/Cell Phone: _____

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

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company: _____ Subscriber's Full Name: _____

Policy/Social Security Number: _____ Group Number: _____ Birthdate: _____

Secondary Dental Insurance Company: _____ Subscriber's Full Name: _____

Policy/Social Security Number: _____ Group Number: _____ Birthdate: _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you: _____ Phone Number: _____

NOTICE OF PRIVACY PRACTICES

*I understand that, under the Health Insurance Portability Act of 1996 (**HIPPA**), I have certain rights to privacy regarding my protected health information.

*I acknowledge that I have been offered your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

*I authorize Croco Orthodontics to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

*I understand that where appropriate, credit bureau reports may be obtained. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Patient Name: _____

I, _____, have read a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

MEDICAL HISTORY

Name of Physician/Practice: _____ Physician's Phone: _____

- Yes No Are you in good health?
- Yes No Has there been any change in your general health within the past year? If so, when was your last visit and the condition being treated? _____
- Yes No Have you had any serious illness, accidents or operations? If yes, please explain. _____
- Yes No Are you taking any medication (prescription and/or over the counter)? If yes, please list them. _____

Do you have, or have you ever had any of the following diseases or problems?

- | | | |
|--|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Persistent Cough |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizzy Spells or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Trouble |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Adenoids/Tonsils Removed | <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies (Latex, Nickel, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy (Convulsions) | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV or Related Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/Joint Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Defect or Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma or Hayfever | <input type="checkbox"/> Yes <input type="checkbox"/> No High or Low Blood Pressure | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis or Liver Disease | FEMALES ONLY: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Reached menarche? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Ear Pain or Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic/Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? |

- Yes No Are you allergic or have you reacted adversely to any medication? If yes, what? _____
- Yes No Do you use tobacco? If yes, how long? _____
- Yes No Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck? If yes, please explain. _____
- Yes No Do you have any disease, condition or problem not listed above that you think I should know about? If yes, please explain. _____

DENTAL HISTORY

Name of Dentist: _____ Date of your last dental exam and cleaning: _____

- Yes No Have you been told by a physician to take antibiotic before dental procedures?
- Yes No Have you ever injured your neck, head, or jaw?
- Yes No Have you ever injured or damaged any teeth?
- Yes No Have you had wisdom teeth removed?
- Yes No Have any baby or permanent teeth been removed by your dentist?
- Yes No Do you have periodontal disease or bleeding gums?
- Yes No Do you brush your teeth at least twice a day?
- Yes No Are you using fluoride mouth rinse or fluoride supplements?
- Yes No Was there any thumb or finger sucking? If yes, until what age? _____
- Yes No Do you clench or grind your teeth?
- Yes No Do you have any clicking, popping or grating noise in your jaw joint?
- Yes No Do you have any discomfort, tightness or spasms of facial or neck muscles?
- Yes No Do your jaws ever catch or lock?
- Yes No Have you seen any other orthodontists in the past?
- Yes No Would you object to wearing orthodontic appliances should they be indicated?
- Yes No Are you able to breathe through your nose?
- Yes No Are you aware that some appointments will be during school/work hours?

What are your Dentist's chief concerns? _____

What are your chief concerns in seeking treatment? Is there anything you would like to change? _____

I certify that I have read and understand the previous information to the best of my knowledge, and all questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health.

Signature: _____

Date: _____

Reviewed by: _____

Signature of Doctor: _____