Arigo ORTHODONTICS

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Please fill out this form and bring it with you to your first appointment. We look forward to meeting you.

Part I - Patient Information

Name _____
(first) (middle) (last) (nickname)

Address _____
(street) (town, state, zip) (phone)

Family e-mail address _____

Gender _____ Age _____ Birthdate _____
School _____ Grade _____
Dentist _____ Physician _____

Primary Person Responsible for Account _____ Birthdate _____
Address _____ Home Phone _____
Occupation _____ Business Phone _____
Employer _____ Business Address _____
Dental Insurance Company _____ Group # _____
Ins. ID# _____ or S.S.# _____ Flexible Spending Account yes no
Secondary Person Responsible for Account _____ Birthdate _____
Address _____ Home Phone _____
Occupation _____ Business Phone _____
Employer _____ Business Address _____
Dental Insurance Company _____ Group # _____
Ins. ID# _____ or S.S.# _____ Flexible Spending Account yes no

Part II- Patient Dental History *(Please complete for the patient being seen today.)*

Do you have a dental cleaning and exam every six months?_____Date of last exam_____
Do you have, or have you had, any of the following: *(Please circle.)*

Family members who have had orthodontics	yes	no
Missing, extracted, or extra teeth	yes	no
Trouble chewing	yes	no
Teeth that are sensitive to heat or cold	yes	no
Bleeding gums or a bad taste in the mouth	yes	no
Root canals, crowns, or bridges	yes	no
Habits like thumb/finger sucking, grinding, or clenching	yes	no
Clicking, popping, or pain in the jaw (TMJ)	yes	no
Injuries to the face, jaw, mouth or teeth	yes	no

Please explain: _____

Part III - Patient Medical History *(Please complete for the patient being seen today.)*

Are you in good health? _____
Have you been treated by a physician for any condition in the last two years? _____

Do you now have any, or have you ever had any of the following? *(Please circle.)*

Heart Disease	yes	no	Tumors, cysts, or cancer	yes	no
Circulation problems	yes	no	Bone/muscle problems	yes	no
Anemia/bleeding disorders	yes	no	Asthma or breathing problems	yes	no
Autoimmune disease	yes	no	Allergies	yes	no
Endocrine problems	yes	no	Seizure disorder	yes	no
Arthritis	yes	no	Fainting or dizziness	yes	no
Hepatitis	yes	no	Cleft lip and/or palate	yes	no
Diabetes	yes	no	Tonsil or adenoid problems	yes	no
Tuberculosis	yes	no	Headaches or earaches	yes	no

If yes, please explain: _____

Please list any medications taken: _____

Are you allergic to or have you ever had a reaction to any medication or drug? _____
Are you allergic to or have you ever had a reaction to latex? _____
Do you need to be pre-medicated with an antibiotic before an invasive dental procedure? _____
Do you regularly take Advil, Aleve, aspirin or other anti-inflammatory products? _____
Do you drink carbonated beverages (soda) on a daily basis? _____ If so, how much? _____
Are you a regular user of tobacco products such as cigarettes or smokeless tobacco, etc? _____
Female patients: To the best of your knowledge, are you pregnant? _____

Please provide any additional information you feel may be helpful in the diagnosis and treatment of your condition:

Part IV- Other Information

What would you like to find out by coming to see Dr. Arigo? _____

Has there been any previous orthodontic treatment or consultation? _____
How did you hear about our office? _____

Dr. Arigo has my permission to obtain diagnostic materials he deems necessary for orthodontic evaluation. I also authorize him to provide other health care providers with information regarding my/my child's orthodontic care if considered appropriate. I also understand it is my responsibility to keep Dr. Arigo's office informed of any change in medical or dental health status.

_____
Parent/Patient's Signature Date