BARRY I MATZA, DMD 5100 Town Center Circle Boca Raton, FL 33486 matzaorthodontics.com info@matzaorthodontics.com

PATIENT INFORMATION

Patient's Last Name: | Patients' First Name | Patient Prefers to be Called | Gender M/F

Patient's DOB | Patient's Age | Patient's E-Mail Address | Patient's Social Security #

Patient Street Address | Patient's City, ST Zip | Patient's Home Ph # | Patient's Cell #

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

Whom may we thank for referring you to our office?

Are other family members treated here? Yes No If so, who?:

Sibling/Children information:

1. Sibling/Child Full Name | M/F | Sibling/Child DOB
3. Sibling/Child Full Name | M/F | Sibling/Child DOB
2. Sibling/Child Full Name | M/F | Sibling/Child DOB
4. Sibling/Child Full Name | M/F | Sibling/Child DOB

RESPONSIBLE PARTY INFORMATION

Resp Party Last Name: | Resp Party First Name | Resp Party Email Address | Relationship to patient

Marital Status: Single Married Divorced Widowed Separated

Resp. Party Street Address | Resp. Party City, ST Zip | Resp. Party Home Ph # | Resp. Party Work Ph # | Resp. Party Cell Ph #

How long at this address: _____

Resp. Party Social Security # | Resp. Party Employer | Resp. Party Occupation | # Yrs Current Employer | Resp. Party DOB

Previous Address if less than 3 yrs at current residence:

Previous Address | Previous City, ST Zip | Resp Party email address

Spouse/Partner Information:

Spouse/Partner | Relationship to Patient | Occupation | # Yrs Current Employer | Spouse/Partner DOB

Spouse/Partner Social Security # | Spouse/Partner Work Ph # | Spouse/Partner Cell Ph# | Spouse/Partner Email Address

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Last Name: | Insured's First Name | Insured's Soc. Sec. # | Insurance Co Name | Insured's Group #

Insurance Co St Address | Insurance Co. City, ST Zip | Insurance Co Ph # | Insureds' Employer | Insured's DOB

Do you have dual insurance coverage? Yes No Do you have a pre-tax flexible spending account?: Yes No

EMERGENCY INFORMATION – RELATIVE OR FRIEND NOT LIVING WITH YOU

Emergency contact name | St Address | City, ST Zip

Relationship | Emergency contact's home Ph# | Emergency contact's work Ph# | Emergency contact's cell Ph#

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PATIENT INFORMATION

Patient's Dentist | Last Dental Visit

Orthodontic	Dental	Medical
Has an orthodontist been previously consulted? ☐ **yes** ☐ **no**	**What was your dentist's main concern?**	**Physician's Name:** **Last physical exam:** **Hospitalizations?**
In your own words, describe your orthododontic problems and what would you like orthodontics to accomplish?	**Is there any dental work that needs to be completed prior to orthodontic treatment?** ☐ **yes** ☐ **no**	**Is _____ under the care of a physician at this time?** ☐ **yes** ☐ **no** **If yes, please explain reason for physician's care:**
Indicate the patient's feelings toward orthodontic treatment? ☐ **eager to get started** ☐ **complacent** ☐ **not committed to cooperate**	**Are antibiotics necessary for teeth cleanings?** ☐ **yes** ☐ **no**	**List any medications being taken at this time:** **Are you currently or have you taken bisphosphonates?** ☐ **yes** ☐ **no**
Hobbies/Comments:	**What was the date of your last cleaning?**	**List any drugs/things that _____ is allergic to or has a reaction to:**

Please complete _____ medical history information. Please check yes or no if you have or have had:

Abnormal Adenoids/Tonsils	☐ yes ☐ no	Endocrine problems	☐ yes ☐ no	Osteoporosis/Osteopenia	☐ yes ☐ no
AIDS/HIV	☐ yes ☐ no	Epilepsy	☐ yes ☐ no	Prolonged bleeding	☐ yes ☐ no
Allergies	☐ yes ☐ no	Faintness/Dizziness	☐ yes ☐ no	Psychiatric treatment	☐ yes ☐ no
Arthritis	☐ yes ☐ no	Fever blisters	☐ yes ☐ no	Rad/Chemo/Blood therapy	☐ yes ☐ no
Artificial heart valves	☐ yes ☐ no	Headaches (frequent)	☐ yes ☐ no	Respiratory Problems	☐ yes ☐ no
Asthma	☐ yes ☐ no	Heart murmur	☐ yes ☐ no	Rheumatic/Scarlet/Yellow fever	☐ yes ☐ no
Bone disorders	☐ yes ☐ no	Heart trouble	☐ yes ☐ no	Scoliosis	☐ yes ☐ no
Blood disease	☐ yes ☐ no	Finger/Thumb/Lip Sucking	☐ yes ☐ no	Shortness of breath	☐ yes ☐ no
Cancer	☐ yes ☐ no	Hemophiliac	☐ yes ☐ no	Sinus Trouble	☐ yes ☐ no
Cardiac pacemaker	☐ yes ☐ no	Hepatitis	☐ yes ☐ no	Stroke	☐ yes ☐ no
Congenital heart lesions	☐ yes ☐ no	Herpes	☐ yes ☐ no	TMJ problems	☐ yes ☐ no
Chronic cough	☐ yes ☐ no	Jaundice	☐ yes ☐ no	Thyroid problems	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Joint swelling	☐ yes ☐ no	Tonsils removed	☐ yes ☐ no
Drug addiction	☐ yes ☐ no	Kidney disease	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Ear Problems	☐ yes ☐ no	Liver disease	☐ yes ☐ no	Artificial bones/joints	☐ yes ☐ no
Emotional problems	☐ yes ☐ no	Organ transplant	☐ yes ☐ no	Wound healing problems	☐ yes ☐ no
		Muscle or joint disorder	☐ yes ☐ no	Whiplash	☐ yes ☐ no
Is the patient pregnant?	☐ yes ☐ no				
Has patient reached puberty?	☐ yes ☐ no	Is bite uncomfortable?	☐ yes ☐ no	Cheek, tongue or lip chewing?	☐ yes ☐ no
Any facial injuries?	☐ yes ☐ no	Severe frequent headaches?	☐ yes ☐ no	Clenching teeth?	☐ yes ☐ no
Mouth breathing?	☐ yes ☐ no	Trauma to the jaw?	☐ yes ☐ no	Grinding teeth?	☐ yes ☐ no
Missing/extra permanent teeth?	☐ yes ☐ no	Does the patient smoke?	☐ yes ☐ no	Fingernail habit?	☐ yes ☐ no
Speech problems?	☐ yes ☐ no	Abnormal height or weight?	☐ yes ☐ no	Drink energy drinks regularly?	☐ yes ☐ no
Pain or clicking on opening mouth?	☐ yes ☐ no	Adopted? Does he/she know?	☐ yes ☐ no		
		Latex allergy?	☐ yes ☐ no		

Please explain ANY Disease, Medical or Dental Condition that is not mentioned above:

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in medical status. I understand that where appropriate; credit bureau reports may be obtained.

Signature (Parent's signature if minor) Date

Updates- Date Initial | Updates- Date Initial | Updates- Date Initial