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CROCO ORTHODONTICS

Phone: (319) 545-7600
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Matthew Croco D.D.S., M.S.
Board Certified Specialist in Orthodontics for Children and Adults

PATIENT INFORMATION

Last name: _____ First name: _____ Middle: _____ Sex: ☐M ☐F Birthdate: _____

Marital status: ☐Married _____ ☐Single ☐Separated ☐Divorced ☐Widowed
Spouse's name

Address: _____ City: _____ State: _____ Zip code: _____ How long at this address? _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____ No. years employed: _____

Social security number: _____ E-mail address: _____

Whom may we thank for referring you to our office? _____

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

SPOUSE'S / PARTNER'S INFORMATION

Last name: _____ First name: _____ Middle: _____ Birthdate: _____

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

Cell phone: _____ Work phone: _____ Social security number: _____

Employer: _____ Occupation: _____ No. years employed: _____

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 and Accountability Act of 1996 (**HIPAA**), 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 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 dependent's behalf.

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?

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

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: _____

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?	Yes No

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 health.

Signature: _____ Date: _____

Reviewed by: _____ Signature of Doctor: _____