Drs. DeMarco and Tilkin, P.A.

Orthodontics for Children and Adults

Welcome to our practice! We look forward to taking care of you and giving you ***the Smile of a Lifetime***.

Patient's Name _____ (Title / Last / First / MI) Nickname _____

Sex _____ Age _____ Birthdate ____/____/____ Home Phone (____) _____

Address _____ City _____ State _____ Zip Code _____

Email Address (to confirm appointments) _____ Cell Phone (____) _____

General Dentist _____ Last Visit Date ____/____/____ Physician _____

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

Any siblings or relatives treated here? Who? _____

Special interests or hobbies? _____

Patients 18 years or older: Occupation _____ Office Phone (____) _____

Employer _____

Name of spouse (if applicable) _____

Patients younger than 18: School _____ Grade _____ Height _____ Weight _____

Parent 1 _____ (Title / First / Last) Occupation _____

Address _____ Home Phone (____) _____

Employer _____ Office Phone (____) _____

Email _____ Cell Phone (____) _____

Parent 2 _____ (Title / First / Last) Occupation _____

Address _____ Home Phone (____) _____

Employer _____ Office Phone (____) _____

Email _____ Cell Phone (____) _____

Marital Status of Parents _____

Parent 1 Relationship To Child? Biological _____ Other _____ **Parent 2 Relationship To Child?** Biological _____ Other _____

MEDICAL/DENTAL HISTORY

Does the patient have now or have a history of any of the following? Please check all that apply.

_____ **allergies** to medications
_____ **allergies** to latex, plastic or metal
_____ bone building medications (Biophosphonates)
_____ arthritis (bone/joint disorders)
_____ asthma (breathing disorders)
_____ cancer
_____ cleft lip/palate
_____ convulsions/epilepsy
_____ diabetes
_____ emotional problems
_____ endocrine/thyroid/growth problems
_____ frequent colds/ear infections
_____ handicaps/disabilities
_____ frequent headaches
_____ **heart murmur**/disease,HBP/defects
_____ hemophilia (bleeding disorders)
_____ infectious diseases or exposure to TB/hepatitis/venereal disease/ HIV/AIDS/blood transfusions
_____ kidney or liver problems
_____ surgery/operations (list with dates)
_____ clenching/grinding of teeth
_____ mouth breathing
_____ speech problems/therapy
_____ thumb/finger/lip sucking, tongue thrust
_____ environmental allergies (dust, grass etc)
_____ smoking
_____ injury to face, mouth, teeth
_____ learning disability
_____ missing or extra permanent teeth
_____ clicking/painful jaw joints
_____ periodontal disease/surgery

If the patient is under the care of a physician or taking any medications, please explain condition and list medications:

_____

What are your primary concerns and expectations regarding your or your child's orthodontic treatment?

_____

Have you had previous orthodontic evaluations? _____ If yes, date of last visit? _____

FINANCIAL INFORMATION (please give your insurance card/form/referral to the receptionist - thank you)

Person(s) responsible for account _____ relationship _____

Do you have dental insurance _____ Yes _____ No Do you have orthodontic coverage? _____ Yes _____ No

First Insurance Co. Name _____ Group# (Plan, Local, or Policy#) _____

Ins. Co. Address _____ Phone (____) _____

Policy Owner's Name _____ Birthdate ____/____/____

SS # _____ - _____ - _____ Relationship _____

Do you have a Secondary Insurance? _____ Yes _____ No

I HAVE RECEIVED AND REVIEWED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES

Signature _____ **Relationship** _____ **Date** ____/____/____