

Welcome to the office of Mel Collazo, D.D.S., M.S.

Specializing in Orthodontics and Facial Orthopedics

Dedicated to Providing the Finest Orthodontic Care

“We would like to get to know you better!”

This information is needed to meet your orthodontic needs. It is considered strictly confidential.

PATIENT INFORMATION

Today's Date _____

Patient's Name _____ Nickname _____ Female Male

Birthdate _____ Age _____ Who is accompanying you today _____

Street Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

Email Address: _____ Would you like an email reminder? Y ___ N ___

Would you like a text reminder? Y ___ N ___ Carrier for text reminders: ATT Sprint Verizon Nextel T-Mobile Other _____

Patient's Employer/School _____ Occupation _____

Spouse's Name _____ Relationship to patient _____

Spouse's Employer _____ Occupation _____ Work Phone _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account _____ Relationship _____

If Minor: Father's Name _____ Email Address _____

Street Address _____ City/State/Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

Father's Employer _____ Occupation _____

If Minor: Mother's Name _____ Email Address _____

Street Address _____ City/State/Zip _____

Mother's Employer _____ Occupation _____

Cell Phone _____ Work Phone _____ Home Phone _____

Would you like a text reminder: Y ___ N ___ Carrier for text reminders? ATT Sprint Verizon Nextel T-Mobile Other _____

Patient lives with Mother ___ Father ___ Both ___ Parent's Marital Status Married Single Separated Divorced

OTHER

What is your chief concern(s)? _____

Has the patient had a previous Orthodontic consultation? Y ___ N ___ Previous Orthodontic treatment? Y ___ N ___

If yes, when, where, Dr.'s name _____

Relative(s) who is a patient here? _____

Friend(s) who is a patient here? _____

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

Emergency Contact _____ Relationship _____ Phone _____

Mel Collazo, D.D.S., M.S.
Specializing in Orthodontics and Facial Orthopedics
Dedicated to Providing the Finest Orthodontic Care

This information is needed to meet your orthodontic needs. It is considered strictly confidential.

DENTAL HISTORY

How does the patient feel about wearing "braces"? _____
Does anyone else in the family have a similar orthodontic problem? _____
Has anyone in your family received orthodontic treatment? _____
Patient's Dentist _____ Last Dental Exam _____
Other Dental Specialist _____

Does the patient currently have, or has the patient ever had any of the following? (please circle)

Dental pain	Mouth Breather	Sensitivity
Thumb/finger habit	Head/Neck injury	Nail biting
Jaw/Joint pain	Head/Neck pain	Periodontal Disease
Cold sores	Gum surgery/Food traps	Wisdom tooth extractions
Implants	Veneers	Bridges

TMJ Symptoms: circle (clenching / grinding / headaches / jaw pain / ear aches / popping / locking / other)

Are you aware that some of the appointments will be during school/work hours? Yes _____ No _____
Is there any other dental information that you feel we should know about? _____

MEDICAL HISTORY

Patient's Physician _____
Patient's overall health status? Excellent _____ Good _____ Poor _____ Other _____
Is the patient allergic to anything (drugs, food, pollen)? _____
Is the patient currently taking any medications? _____

Is the patient presently under medical care? Y/N When/ Where? _____

Has the patient ever been hospitalized? Y/N When/Where? _____

Does the patient currently have, or has the patient ever had any of the following? (please circle)

Adenoids removed	Dizziness	Major Surgery
AIDS (HIV)	Drug addiction	Nasal/airway problems
Arthritis	Epilepsy/seizures	Nervous Disorders
Anemia	Heart problems	Pneumonia
Asthma	Hepatitis	Sinus problems
Auto accident	High Blood Pressure	Speech problems
Bleeding disorders	Heart Problems	Tobacco usage
Bone Disorders	Immune Disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic Surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	Venereal Disease

Is there any other medical information that you feel we should know about? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Collazo and his staff to perform a complete orthodontic evaluation.

Signature: _____ Date: _____