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

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_____

Address _____City/State/Zip_____

Email Addres _____Would you like an email reminder? Y_____N____

Cell Phone_____ Work Phone _____Other Phone_____

Would you like a text reminder? Y__N__Carrier for text reminders: ATT Sprint Verizon Nextel T-Mobile Other_____

Employer/School _____ Occupation _____

RESPONSIBLE PARTY INFORMATION (if same check here____)

Name _____Relationship_____Birthdate____/_____/_____

Address _____ City/State/Zip _____

Email Address_____ Would you like an email reminder? Y_____N_____

Cell Phone _____Work Phone _____Other Phone_____

Would you like a text reminder: Y__N__Carrier for text reminders? ATT Sprint Verizon Nextel T-Mobile Other_____

Employer_____Occupation _____No. years employed_____

Spouse's Name _____Relationship to patient _____

Address _____City/State/Zip_____

Cell Phone _____ Work Phone_____Other Phone _____

Employer_____Occupation_____No. years employed_____

Patient lives with Mother____ Father____ Guardian_____ Parent's Marital Status ❑ Married ❑ Single ❑ Separated ❑ Divorced

OTHER

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

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?_____

Emergency Contact_____ **Relationship**_____**Phone**_____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent / Guardian Signature_____**Date**_____

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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 (clinching / 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 in the last 12 months? 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? _____
_____

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. 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.

Parent / Guardian Signature:_____ **Date:**_____