

WELCOME

To Dr. Richard U. Mattson's
Orthodontic Office

ADULT

Date:

Patient Name: _____ Male: _____ Female: _____ Birthdate: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____ Single _____ Married _____ Divorced _____ Widowed _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Occupation: _____

Employer: _____

General Dentist: _____ Last Visit: _____

Family Members Treated in our office? _____

PRIMARY DENTAL INSURANCE COVERAGE

Orthodontic coverage? Yes _____ No _____

Policy Holder Name: _____ Birthdate: ____/____/____

Policy Holder Employer: _____

Dental Ins. Co. Name: _____

Address: _____

Insurance Co. Phone Number: _____

Group #: _____ Insurance ID# or SS# _____

Do you have any of the following?

Y	N	Heart Disease	Y	N	AIDS or HIV+	Other: _____
Y	N	Tuberculosis	Y	N	Cancer	_____
Y	N	Kidney Disease	Y	N	Stroke	_____
Y	N	High Blood Pressure	Y	N	Abnormal Bleeding	_____
Y	N	Hepatitis	Y	N	Allergy to any Drugs	
Y	N	Rheumatic Fever	Y	N	Clicking Jaw Joints	Please list all medications being taken.
Y	N	Heart Murmur	Y	N	Frequent Headaches	_____
Y	N	Diabetes	Y	N	Grinding/Clenching Teeth	_____
Y	N	Epilepsy	Y	N	Pain in the Jaw Joints	_____
Y	N	Dialysis/Transplant/Transfusion/Hospitalizations				_____

Name of Physician: _____

Are you currently under the care of a physician? Y N

SIGNATURE OF PATIENT: _____