Mark P. Hatala, D.D.S.
Practice Limited to Orthodontics
www.hatalaortho.com

Welcome
To Hatala Orthodontics

165 Riverside Drive
Johnson City, NY 13790
Phone: (607) 644-9100
E-mail: hatalaortho@stny.rr.com

Please fill out this form as completely as possible prior to your Initial Orthodontic Examination Appointment **Thank You!**

(Please Print)

About You

☐ Male ☐ Female Today's Date _____

Name _____ _____ _____ ☐ Mr ☐ Mrs ☐ Ms ☐ Dr
Last *First* *MI*

I prefer to be called _____ Birthdate ____/____/____ Age _____

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Home Address _____ Apt. # _____

_____
City *State* *Zip*

Home # _____ Cell / Other # _____ E-mail _____

Employer _____ Job Title _____

Work # _____ Ext _____ Years Employed _____ Soc. Sec. # _____

The best time and place to reach you _____

How did you hear about our office? _____

Other family members seen by us _____

Spouse Information

☐ Male ☐ Female

Name _____ _____ _____ ☐ Mr ☐ Mrs ☐ Ms ☐ Dr
Last *First* *MI*

Address (if different from above) _____

Home # _____ Soc. Sec. # _____ Birth-date ____/____/____

Employer _____ Job Title _____ Work # _____ Ext _____

Person Responsible for Account

His/Her Name _____ Relationship_____

Address (if different from above) _____

Home # _____ Cell / Other # _____ E-Mail _____

Soc. Sec. # _____ Birthdate ____/____/____ Years employed at current job _____

Employer _____ Job Title _____ Work # _____ Ext _____

Orthodontic Insurance

Primary Orthodontic Coverage? ☐ **Yes** ☐ No Dental Coverage? ☐ **Yes** ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ ID # _____

Secondary Orthodontic Coverage? ☐ **Yes** ☐ No Dental Coverage? ☐ **Yes** ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ ID # _____

Dental Care Information

Dentist's Name _____ Date of Last Visit _____

What is your primary concern about your teeth? _____

Have you had other Orthodontic consultations / treatment? _____

_____ Orthodontist _____

Your attitude toward orthodontic treatment: ☐ Very motivated ☐ Will cooperate if needed ☐ Not motivated

Our office is HIPPA Compliant and meets or exceeds the standards of infection control mandated by OSHA, the CDC, and the ADA.

Please Continue

Dental Information

Your current Dental health is ☐ Good ☐ Fair ☐ Poor

Have you had or do you notice any of the following? (check if "Yes")

☐ Traumatic injury to Teeth, Mouth or Chin (Please Circle)
☐ Pain or tenderness around ear, joint, or side of face (TMJ / TMD)
☐ Teeth sensitive to hot, cold, or pressure
☐ Missing or extra permanent teeth
☐ Ever taken Phen-Fen (also known as Redux or Pondimin)? When? _____
☐ Pain, swelling, or bleeding of gums
☐ Periodontal treatment
☐ Speech Problems
☐ Breathe through mouth
☐ Smoke or use tobacco in any form
☐ Ever taken oral biphosphonates such as Fosamax, Actonel, or Boniva? Date started / Stopped: _____
☐ Ever received intravenous (IV) biphosphonates such as Zometa (Zoledronate) or Pamidronate (Aredia)? Date started / Stopped: _____

If Yes, please explain _____

_____

Medical Information

Your current Physical health is ☐ Good ☐ Fair ☐ Poor

Physician's Name _____ Date of Last Visit ____/____/____ Phone # _____

If currently under a Physician's care, for what reasons? _____

If taking any medications, please list: _____

Do you require any medications prior to dental work? _____

Women: Are you pregnant? _____ Week#_____

Do you have, or have you ever had any of the following? (check if "Yes")

☐ Abnormal Bleeding
☐ ADD / ADHD
☐ Anemia
☐ Artificial Bones / Joints / Valves
☐ Asthma
☐ Arthritis
☐ Cancer / Chemotherapy
☐ Congenital Heart Defect
☐ Diabetes
☐ Difficulty Breathing
☐ Epilepsy / Fainting / Seizures
☐ Fever Blisters / Herpes
☐ Frequent Headaches
☐ Growth Disorders
☐ Handicaps / Disabilities
☐ Heart Murmur
☐ Heart Surgery / Pacemaker
☐ Hepatitis
☐ Hemophilia
☐ Hepatitis
☐ High / Low Blood Pressure
☐ HIV+ / AIDS
☐ Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Tuberculosis (TB)
☐ Venereal Disease

Comments regarding above: _____

_____

Please list any serious medical conditions that you have ever had: _____

Do you have Allergies to any of the following? (check if "Yes")

☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Erythromycin
☐ Latex
☐ Metals / Plastics
☐ Penicillin
☐ Tetracycline

Please list any other drug / material allergies you have: _____

Emergency Information

Name of neighbor or relative not living with you _____

Home # _____ Cell / Other # _____ Relationship _____

Address _____

Please bring this completed form to your Initial Orthodontic Exam Appointment.
We look forward to meeting you!

The information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform Hatala Orthodontics of any changes to this information. I authorize the dental staff of Hatala Orthodontics to perform any dental services during diagnosis and treatment with my informed consent.

Signed _____ Date _____

This Office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signed _____ Date _____

OFFICE USE ONLY

I have verbally reviewed the Medical and Dental information above with the patient.
Initials _____Date _____ Doctor's Comments: _____

_____

_____

_____

Thank you for filling out this form!