Dino A. Cacchiotti, DDS, MS

Specialist in Orthodontics
1042 W. Ivy, Moses Lake, WA 98837
201 H Street, Quincy, WA 98848

Today's Date ____________________

Patient Registration

Welcome to our office! Please answer the following questions.

PATIENT INFORMATION (CONFIDENTIAL)

Name: (Last) ______________________ (First) _____________________ (Nickname) ______ _____ ______
Male ☐ Female ☐ Birthdate ________________ Age_____ Occupation _________________________
Address: (Street) ____
(City)________________________________ (State) __________ (Zip) ___________
Phone: (Home) ______________________ (Work) ____________________ (Cell) _______________________
Parent/Guardian Name: ____
Address: (Street) ____
(City) ______________________________ (State) __________ (Zip) ____________
Phone: (Home) ______________________ (Work) _____________________ (Cell) ______________________
Drivers License # ____

E-Mail Address:____

Dentist Name: ____
Whom can we thank for referring you to our office?____
What are your specific concerns about your teeth? ____
Do you like your smile? _____________
Are you self-conscious about your teeth? _________ Chin? ________ Nose? ________ Lips? _________

Insurance Information

Primary Insurance Company ___________________________________ Group/I.D. # __________________
Address ____ Phone # ____________________
Name of Insured __________________________ Birthdate _______________ SS# _______________________
Insured's Employer ____
Address ____Phone # ____________________
Secondary Insurance Company _________________________________ Group/I.D. # __________________
Address ____ Phone # ____________________
Name of Insured __________________________ Birthdate _______________ SS# _______________________
Insured's Employer ____
Address ____Phone # ____________________

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

Signature ____
Responsible Party

Dino A. Cacchiotti, DDS, MS

Dental History

Yes No Do you see a dentist regularly? Last appointment date ________________________
Yes No Have your dental experiences always been well?
Yes No Were X-Rays taken?
Yes No Is your jaw ever tired or sore?
Yes No Have you had orthodontic treatment before?
Yes No Does your jaw click or pop?
Yes No Do you usually breathe through your mouth?
Yes No Are any teeth sensitive to hot? Cold? Sweets?
Yes No Do you clench or grind your teeth?
Yes No Have you ever had an undesirable reaction to local anesthetics (Novocain, etc)?
Yes No Have you ever had gum disease?
Yes No Do your gums bleed when brushed?
Yes No Have you ever had an undesirable reaction to Penicillin or other antibiotics?
Yes No Do you now or have you ever sucked your thumb or fingers?

Medical History

Yes No Is the patient currently under the care of a physician?
Name of physician and reason ____
Yes No Ever been hospitalized or had a major operation? Discuss ______________________________
Yes No Are you taking any medications? Discuss ___________________________________
Yes No Do you have any allergies? Please list ____
Yes No If female: Are you pregnant?
Yes No Are you now or have you been in speech therapy?

Have you ever had:

Yes No Rheumatic Fever
Yes No Heart Trouble or Murmur
Yes No High Blood Pressure
Yes No Chest Pain
Yes No Swelling of Feet or Ankles
Yes No Stomach or Digestive Problems
Yes No Breathing Problems
Yes No Anemia
Yes No Bleeding Problems
Yes No Jaundice or Hepatitis
Yes No Other Liver Problems
Yes No Drug Reactions
Yes No Hay Fever
Yes No Asthma
Yes No Sinusitis

Yes No Tuberculosis
Yes No Diabetes
Yes No AIDS/HIV Positive
Yes No Kidney or Urinary Problems
Yes No Radiation Treatment
Yes No Cancer or Tumor
Yes No Convulsions, Seizures or Fainting
Yes No Arthritis
Yes No Venereal Disease
Yes No Endocrine Disturbance
Yes No Psychological or Emotional Problems
Yes No Frequent Headaches
Yes No Latex Allergy
Yes No Metal Allergy
Yes No Other (Discuss) _________________

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Do you use Tobacco products? ________________ Please describe __________________

Are you in need of any type of pre-medication (due to heart murmur, hip replacement, etc)? _______

Is there any other condition we should know about? _______________________________

Authorization

I certify that the above information is true. I understand that this information will be used by Dr. Cacchiotti to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform Dr. Cacchiotti.

Signed ____ Date _____________

Parent or Guardian if patient is a minor