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 child's Initial Orthodontic Examination Appointment **Thank You!**
(Please Print)

About Your Child

Today's Date ______________________________

Child's Name ____ ☐ Male ☐ Female
Last *First* *MI*

He / She prefers to be called ______________________ Birth-date _____/_____/_____ Age ___________

Home Address ____ Apt. # ___________

____
City *State* *Zip*

Home # __________________ Cell / Other # __________________ E-Mail ______________________

School ______________ Grade___ Hobbies / Sports________________ How did you hear about our office? ______________

List names and ages of brothers / sisters ____

Who is accompanying your child today? Name__________________________ Relation ______________

Person Responsible for making appointments: Name______________________ Home # __________ Work #__________

Parent's Information

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
Who has primary custody? ☐ Mother ☐ Father ☐ Other______________

Mother's Name ____________________________________ ☐ Mother ☐ Step Mother ☐ Guardian

Home # __________________ Cell / Other # __________________ E-Mail ______________________

Soc. Sec. # ______________________________ Birth-date _____/_____/_____ Years employed at current job __________

Employer ______________________________ Job Title ______________ Work # __________________ Ext _______

Father's Name ____________________________________ ☐ Father ☐ Step Father ☐ Guardian

Home # __________________ Cell / Other # __________________ E-Mail ______________________

Soc. Sec. # ______________________________ Birth-date _____/_____/_____ Years employed at current job __________

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. # ______________________________ Birth-date _____/_____/_____ 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 child's teeth? ____

Have you had other Orthodontic consultations / treatment? ______________________ Orthodontist ______________

Patient's attitude toward orthodontic treatment: ☐ Very motivated ☐ Will cooperate if needed ☐ Not motivated

Please Continue

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

Dental Information

Your child's current Dental health is ☐ Good ☐ Fair ☐ Poor

Your child brushes / flosses everyday? ☐ Yes ☐ No

Has your child had or noticed 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**
- ☐ **Clenching / Grinding Teeth**
- ☐ **Thumb / Finger sucking**
- ☐ **Nail Biting**
- ☐ **Ever taken Phen-Fen? (Also known as Redux or Pondimin). When?_________**
- ☐ **Pain, swelling, or bleeding of gums**
- ☐ **Periodontal treatment**
- ☐ **Speech Problems**
- ☐ **Breathes through mouth**
- ☐ **Nursing Bottle Habits**
- ☐ **Lib Sucking / Biting**
- ☐ **Tongue Thrust**

If Yes, please explain ____

List any musical instruments played: ____

Medical Information

Your child's current Physical health is ☐ Good ☐ Fair ☐ Poor

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

Is your child under a Physician's care? For what reason? ____

Please list all medications your child is currently taking: ____

Does your child require any medications prior to dental work? ____

Has your child ever had any of the following? (check if "Yes")

- ☐ **Abnormal Bleeding**
- ☐ **ADD / ADHD**
- ☐ **Any Operations**
- ☐ **Artificial Bones / Joints / Valves**
- ☐ **Asthma**
- ☐ **Cancer / Chemotherapy**
- ☐ **Congenital Heart Defect**
- ☐ **Diabetes**
- ☐ **Epilepsy / Fainting / Seizures**
- ☐ **Growth Disorders**
- ☐ **Handicaps / Disabilities**
- ☐ **Hearing Impairment**
- ☐ **Heart Murmur**
- ☐ **Hemophilia**
- ☐ **Hepatitis / Liver problems**
- ☐ **HIV+ / AIDS**
- ☐ **Rheumatic Fever**
- ☐ **Scarlet Fever**
- ☐ **Sickle Cell Disease**
- ☐ **Tuberculosis (TB)**

Please discuss any medical conditions / problems your child has had: ____

____

Has puberty begun? ☐ Yes ☐ No Female patients: Has menstrual cycle started? ☐ Yes ☐ No

Does your child have Allergies to any of the following? (check if "Yes")

☐ Any Medications ☐ Dental Anesthetics ☐ Latex ☐ Metals / Plastics

Please list all of your child's allergies: ____

Emergency Information

Name of neighbor or relative not living with you ______________________

Home # __________________ Cell / Other # __________________ Relationship ______________________

Address ____

Please bring this completed form to your child's 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 my child may need.

Signature of parent or guardian ____________________________________ 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.

Signature of parent or guardian____________________________________ Date ___________

OFFICE USE ONLY

I have verbally reviewed the Medical and Dental information above with the parent / guardian and patient.

Initials __________Date __________ Doctor's Comments: ______________________________

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Thank you for filling out this form!