

Mayo Orthodontics

5970 Fairview Rd

Suite 120

Charlotte, NC 28210

Ph # : 704-554-6455

**Patient Personal Information**

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Student	SSN
Email		School Name	
		Referral Type	

Person responsible/guarantor for paying bills

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance? ___ Yes ___ No
Do you have Secondary Dental Insurance? ___ Yes ___ No

Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

Allergic To	<input type="checkbox"/> Y <input type="checkbox"/> N Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Gall Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin or Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Other Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain Upon Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
Check, if applicable	<input type="checkbox"/> Y <input type="checkbox"/> N Color Blindness	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection	<input type="checkbox"/> Y <input type="checkbox"/> N Contact Lenses	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N Unusual Weight Loss
<input type="checkbox"/> Y <input type="checkbox"/> N Angina	<input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Urinate Frequently
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	
<input type="checkbox"/> Y <input type="checkbox"/> N Ankles Swell	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus	Other
<input type="checkbox"/> Y <input type="checkbox"/> N Anorexia		<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems	<input type="checkbox"/> Y <input type="checkbox"/> N See Scanned Documents: Pt Note
<input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis		<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Persistent Diarrhea |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters | <input type="checkbox"/> Y <input type="checkbox"/> N Premedicate |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren | |

Dental Questionnaire

- Are you happy with your smile ? _____
- Have you ever had orthodontic treatment ? _____
- Name of previous Dentist/ Phone _____
- Date of your last exam and cleaning _____
- Date of your last full series x-rays _____
- Do you regularly use dental floss ? _____
- Do your gums bleed while brushing or flossing ? _____
- Have you had any head, neck or jaw injuries ? _____
- Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____
- Do you clench or grind your teeth ? _____

Additional Comments

Medical Questionnaire

- Emergency contact name and phone and relationship _____
- Medical Questionnaire**
- Family Physician/phone _____
- Are you currently under care of a Physician ? Condition being treated? _____
- Are you currently taking any medication ? Please List _____
- Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____
- Do you use alcoholic beverages ? _____
- Do you smoke or chew tobacco ? _____
- Are you pregnant/due date? _____
- Do you have menstrual period problems/ hormone replacement therapy ? _____
- Are you on birth control pills / fertility drugs ? _____
- Any Disease, Condition or Problem not Listed ? Please list _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date