WELCOME TO OUR OFFICE .....…….

Lawrence F. Cacchiotti, D.D.S., M.S.
1111 S. 40th Ave., Yakima, WA, 98908
509-966-2200

PATIENT INFORMATION (CONFIDENTIAL):

TODAY'S DATE: _____
Name: Last _____ MI _____ First _____
Preferred Name: _____DOB: _____ Age: _____ Male/Female
Patient Social Security No.: _____
Address: _____
City _____ State _____ Zip_____
Patient Phone: Mobile: _____ Home: _____ Work:_____
If Student, Name of School: _____
Patient E-Mail Address: _____
Patient Employer: _____
Patient Occupation: _____
Circle appropriate status: Minor Single Married Separated Divorced Widowed
Who may we thank for referring you to our office: _____
Patient Dentist: _____ Patient Physician: _____
When was patient's last dental visit? _____Is all dental work up to date? _____

IF PATIENT IS A MINOR - PARENT/GUARDIAN INFORMATION:

- ***Please circle party who is financially responsible for account:*** *Father Mother Other*
- ***Circle appropriate status for parents/guardians:*** *Married Separated Divorced Widowed*

Mother/Guardian Name: _____
DOB: _____ SSN: _____ E-Mail Address: _____
Address: _____ City: _____ State: _____Zip: _____
Home Phone: _____ Work Phone: _____ Mobile:_____
Employer: _____Occupation: _____

Father/Guardian Name: _____
DOB: _____ SSN: _____ E-Mail Address: _____
Address: _____ City: _____ State: _____Zip: _____
Home Phone: _____ Work Phone: _____ Mobile: _____
Employer: _____Occupation: _____

IF PATIENT IS AN ADULT - SPOUSE'S INFORMATION: (if applicable)

Spouse's Name: _____DOB: _____ SSN: _____
Employer: _____Occupation: _____
Home Phone: _____ Work Phone: _____ Mobile:_____

ORTHODONTIC INSURANCE INFORMATION: **State Pay/Medical Coupons? Yes ☐ No☐
****If State Pay Insurance, has any other office sent in a request for Orthodontic Treatment? Yes ☐ No☐**

Name of insured: _____ Relationship to patient: _____
Insurance Company: _____Ins. Phone: _____
Insurance Company Address: _____
Group #: _____ Policy I.D. #: _____

ADDITIONAL ORTHODONTIC INSURANCE INFORMATION:

Name of insured: _____ Relationship to patient: _____
Insurance Company: _____Ins. Phone: _____
Insurance Company Address: _____
Group #: _____Policy I.D. #: _____

HEALTH INFORMATION:

Has patient had injuries to teeth or mouth?	Yes	No
Does patient suck finger or thumb?	Yes	No
Did patient suck finger or thumb?		
When did it stop? _____	Yes	No
Does patient breathe through mouth more than nose?	Yes	No
Has the patient been seen or treated for orthodontics before?	Yes	No
Has the patient had chronic tonsillitis?	Yes	No
Were tonsils and/or adenoids removed?	Yes	No
If so, when? _____		
***Does patient have any condition which requires pre-medication with antibiotics before dental treatment?**	**Yes**	**No**
Does patient take medication on a daily basis?	Yes	No
If so, please list medication(s):		

_____

Does patient have a history of any of the following (if so, please circle):

Aids	Asthma
Glaucoma	Fainting
Hepatitis	Frequent headaches
Frequent neckaches	Soreness of jaw muscles
Rheumatic fever	Clenching/grinding teeth
Tuberculosis	Clicking/locking jaw joints
Severe bleeding	

Allergies to: _____

Please note any medical or health history that you feel is important for us to know: _____

_____

I affirm that all the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status.

_____ _____

Signature of Patient or Parent/Guardian *Date*

NOTICE OF PRIVACY PRACTICES:

We keep a record of the care services we provide to you. You may ask to see and obtain a copy of that record.

Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed and how you can access your information. A copy of the Privacy Practices is available to you upon request.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ THE ABOVE NOTICE AND I CAN REQUEST A COPY OF OUR NOTICE OF PRIVACY PRACTICES AT ANY TIME:

_____ _____

Printed name of patient or Parent/Guardian *Date*

_____ _____

Signature of patient or Parent/Guardian *Date*