Dr. Joseph A. Dugoni, PC
Specializing in Orthodontics
4707 NE Tillamook St.
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Office: (503) 287-9710
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Today's Date: ____________________________

Patient's First Name ________________________________ Middle Initial ___________ Last Name ___________________________________

Patient's Dentist ____ Referred By _______________________________________

Reason for Orthodontic Consultation ____

Who is financially responsible for this account? ____

Marital status? Married_____________Separated________Divorced________Domestic Partnership______Widow(er)_______Remarried ______

Patient's Information

First Name ____

Last Name ____

Address ____

City/State/Zip ____

Date of Birth ____

Home Phone ____

Cell Phone ____

Occupation ____

Employer ____

Work Phone ____

Email ____

Would you like to receive email reminders? Yes ☐ No ☐

Would you like to receive text message reminders? Yes ☐ No ☐

If yes; who is your cell phone carrier? ______________________

Other Responsible Party Information

First Name ____

Last Name ____

Address ____

City/State/Zip ____

Date of Birth ____

Home Phone ____

Cell Phone ____

Occupation ____

Employer ____

Work Phone ____

Email ____

Would you like to receive email reminders? Yes ☐ No ☐

Would you like to receive text message reminders? Yes ☐ No ☐

If yes; who is your cell phone carrier? ______________________

Primary Dental Insurance Company

Insurance Company Name ______________________________

ID Number ______________________________

Group Number ______________________________

Social Security Number ______________________________

Insurance Phone Number ______________________________

Secondary Dental Insurance Company

Insurance Company Name ______________________________

ID Number ______________________________

Group Number ______________________________

Social Security Number ______________________________

Insurance Phone Number ______________________________

Medical History

Physician's name________________________________City__________________________

Is the patient taking any medication or drugs?______________________________________

Does the patient have a history of major illness or hospital stay?____________________________

Please check the following that the patient has been diagnosed with:

- ☐ Allergies (seasonal)
- ☐ Allergies (metal)
- ☐ Allergies (latex)
- ☐ Allergies (medication)
- ☐ Asthma
- ☐ Congenital Defects
- ☐ Behavioral/Learning problems
- ☐ Diabetes (Type:____________________)
- ☐ Epilepsy
- ☐ Headaches (Frequency____________________)
- ☐ Heart Murmur
- ☐ HIV/Aids
- ☐ Bisphosphonates (ex. Fosamax, Boniva, Actonel, Didronel)
- ☐ Rheumatic Fever
- ☐ Psychiatric Illness (ex. depression, bipolar, anxiety)
- ☐ Tuberculosis

Please describe other medical concerns: ______________________________________

____

Special needs: ____

Have tonsils and adenoids been removed? ________________________If yes, what age? ____________

Has the patient ever sucked a thumb or fingers? ____________________ If yes, until what age? __________

Has the patient or other family members had any previous orthodontic treatment? __________________________

Has the patient been informed of any missing or extra permanent teeth? ______________________________

Does the patient have any jaw pain or noise in the jaw joint? __________________________________

____

Is there a possibility of pregnancy? ________________________ Expected Delivery Date? ____________

Signature _____________________________________ Today's Date __________________