CORO ORTHODONTICS

Member American Association of Orthodontists

Jorge C. Coro, DMD, MS
Ivette M. Coro, DMD, MS
Orthodontics for Adults and Children
896 South Dixie Highway
Coral Gables, FL 33146
P: 305.661.9798 F: 305.666.7332

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS
Jorge C. Coro, DMD, MS

Child History

We would like to welcome you and your child to our office. Our goal is to make your visit pleasant and educational.

Please complete the information below:

Today's Date: _____ ****Confirmation preference – Text ☐ Email ☐** _____

Child's Name:			Nickname:	
☐ Male ☐ Female	Child's Birthdate:	Child's Age:	Home #:	
Home Address:		City/State/Zip:		
School:		Grade:	Hobbies / Sports:	
Who is accompanying your child today? Name:			Relationship:	
Do you have legal custody of this child? ☐ Yes ☐ No				
Whom may we thank for referring you to our office?				
List brothers / sisters with age:				
Parent's Marital Status: ☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Separated
Mother's Information: ☐ Stepmother ☐ Guardian	Home #:		Other #:	
Name:	SS #:		Birthdate:	
Home Address:		How long at present address:	☐ Rent	☐ Own
Previous Address: (if less than 3 years)				
Employer:	Work #:	Ext:	Email:	
How long at current job:	Job Title:			
Father's Information: ☐ Stepfather ☐ Guardian	Home #:		Other #:	
Name:	SS #:		Birthdate:	
Home Address:		How long at present address:	☐ Rent	☐ Own
Previous Address: (if less than 3 years)				
Employer:	Work #:	Ext:	Email:	
How long at current job:	Job Title:			
Person Responsible for the Account: (if different from above)				
Name:	SS #:		Birthdate:	
Home Address:		How long at present address:	☐ Rent	☐ Own
Previous Address: (if less than 3 years)				
Relationship to Patient:	Home #:		Work #:	

I realize it may be appropriate to utilize a credit report in determining a payment plan.

Signature: _____ Date: _____

Orthodontic Insurance

Name of Insurance Company:		Phone #:	
Insurance Address:		City/ State/Zip:	
Subscriber Name:		DOB:	
Employer Name:	Subscriber ID #:		Group #:

S / U A B C

Dental History

Dentist Name: _____ Last Dental Visit: ____/____/_____ Check-up Frequency: _____

Has patient had an orthodontic consult or treatment? Yes ☐ No ☐ If so, when? _____

What is the patient's main orthodontic concern? _____

Speech problems/Therapy?	Yes ☐ No ☐	Brush teeth daily?	Yes ☐ No ☐
Grind or clench teeth?	Yes ☐ No ☐	Floss teeth daily?	Yes ☐ No ☐
Oral habits (thumb/finger habit, lip/nail biting)?	Yes ☐ No ☐	Fluoride treatments?	Yes ☐ No ☐
Injury to face, jaw, teeth or mouth?	Yes ☐ No ☐	Mouth breathing?	Yes ☐ No ☐
Discomfort from teeth or gums?	Yes ☐ No ☐	Snores during sleep?	Yes ☐ No ☐
Pain, tenderness or noise in either jaw?	Yes ☐ No ☐	Requires premedication?	Yes ☐ No ☐
Frequent headaches?	Yes ☐ No ☐	Any missing or extra permanent teeth?	Yes ☐ No ☐
Neck/Shoulder pain?	Yes ☐ No ☐	Apprehensive about dental care?	Yes ☐ No ☐
Frequent sore throats?	Yes ☐ No ☐	Frequently chews gum?	Yes ☐ No ☐

Comments:

_____

Medical History

Physician Name: _____ Date of last Visit: _____/_____/_____

Address: _____ City/State/Zip: _____ Phone: _____

List any medications currently being taken by the patient: _____

List any drug allergies or sensitivities that the patient may have: _____

Rheumatic Fever	Yes ☐	No ☐	Growth Problems	Yes ☐	No ☐
Tuberculosis/Lung Disease	Yes ☐	No ☐	Hormone Therapy	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐	Endocrine Problems	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐	Latex Allergy	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐	Jewelry / Metal Allergy	Yes ☐	No ☐
Heart Attack/Stroke	Yes ☐	No ☐	Nervous Disorders	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Hyperactivity	Yes ☐	No ☐
Congenital Heart Defect	Yes ☐	No ☐	Bone Disorders/Osteoporosis	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Hemophilia	Yes ☐	No ☐	Mononucleosis	Yes ☐	No ☐
Hypertension/High Blood Pressure	Yes ☐	No ☐	Seizures/Epilepsy	Yes ☐	No ☐
Prolonged Bleeding/Transfusion	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
HIV/AIDS	Yes ☐	No ☐	Fainting/Dizziness	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	Handicaps/Disabilities	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Treated for Emotional Problems	Yes ☐	No ☐
Family History of Cancer	Yes ☐	No ☐	Tonsils Removed	Yes ☐	No ☐
Received Radiation Treatment	Yes ☐	No ☐	Adenoids Removed	Yes ☐	No ☐
Ever Been Hospitalized	Yes ☐	No ☐	Other	Yes ☐	No ☐

If any of the above questions were answered "Yes", please explain: _____

_____

Signature: _____ **Date:** _____