McNamara Orthodontics

Orthodontic Patient Information and Health History

Welcome to our office. Please fill out both sides.

1. Tell us about your child...

Patient's Name:_____

Prefers to be called:_____ Age:_____ DOB:_____ Sex: ❑ M ❑ F

Home Address:_____

City, State, Zip:_____

Do you and your child speak English? ❑ Y ❑ N If no, what language do you speak?_____

Siblings (name and age)_____

Patient lives with: ❑ Mother ❑ Father ❑ Both ❑ Other (please specify)_____

Marital status of parents: ❑ Married ❑ Divorced ❑ Separated ❑ Not married

School:_____ Current Grade:_____ Year of Graduation (high school):_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

Parent's Name:_____ Living? ❑ Y ❑ N

Address:_____ City, State, Zip:_____

Home Phone:_____ Cell: _____ Work:_____

Email:_____ Occupation:_____

Best method of contact: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

Parent's Name:_____ Living? ❑ Y ❑ N

Address:_____ City, State, Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Email:_____ Occupation:_____

Best method of contact: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

2. Billing Information

Person 1:

Name:_____

Address:_____

Phone:_____

Place of Employment:_____

Social Security Number:_____

Date of Birth:_____

Person 2:

Name:_____

Address:_____

Phone:_____

Place of Employment: _____

Social Security Number:_____

Date of Birth:_____

Is patient covered by insurance for orthodontic treatment? ❑ Y ❑ N

Insurance company:_____

Please complete the enclosed pink insurance information form if you would like us to file for your reimbursement.

3. Dentist and Physician History

Family Dentist:_____

Address:_____

City, State, Zip:_____

Phone:_____

Family Physician:_____

Address:_____

City, State, Zip:_____

Phone:_____

Referred By:_____

Address:_____

City, State, Zip:_____

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4. Medical History

Has your child ever had:

ADD / ADHD ❑ Y ❑ N
Arthritis ❑ Y ❑ N
Asthma / Breathing Difficulties ❑ Y ❑ N
Autism / Asperger's / PDD-NOS ❑ Y ❑ N
Bleeding Disorders ❑ Y ❑ N
Birth / Congenital Defects ❑ Y ❑ N
Cancer ❑ Y ❑ N
Cold Sores ❑ Y ❑ N
Diabetes ❑ Y ❑ N
Endrocrine Problems ❑ Y ❑ N
Emotional Problems ❑ Y ❑ N
Epilepsy / Seizures ❑ Y ❑ N
Headaches / Migraines ❑ Y ❑ N
Head or Face Injuries ❑ Y ❑ N
Hepatitis ❑ Y ❑ N
Herpes ❑ Y ❑ N
HIV ❑ Y ❑ N
Oral Ulcers ❑ Y ❑ N
Previous Surgery ❑ Y ❑ N
Thyroid Problems ❑ Y ❑ N
Other (specify)_____ ❑ Y ❑ N

If yes to above, please give details:_____

_____

_____

_____

Does your child have allergies (latex, metal, drug, food, etc.)? ❑ Y ❑ N

Please specify:_____

_____

Does your child require antibotic pre-medication for dental procedures? ❑ Y ❑ N

Has your child been under the care of a physician during the past year, other than for routine examinations? ❑ Y ❑ N Condition:_____

Present drugs or medications (name(s) and reason):_____

_____

Has your child reached puberty (menstruation, voice change, hair)? ❑ Y ❑ N

How long ago?_____

5. Dental & Temporomandibular Joint History

Has your child had any unusual dental experiences? ❑ Y ❑ N

Please specify:_____

_____

_____

Date of last dental visit:_____

Were your child's teeth cleaned? ❑ Y ❑ N

Has your child ever been treated for TMJ ("Jaw Joint") problems? ❑ Y ❑ N

6. Does your child have....

1. Difficulty in mouth opening, chewing or swallowing? ❑ Y ❑ N
2. Pain or clicking in jaw joint? ❑ Y ❑ N
3. Pain on chewing, yawning or wide opening? ❑ Y ❑ N
4. Pain in or about the ears or cheeks? ❑ Y ❑ N
5. A jaw that 'locks', 'gets stuck' or feels unusual? ❑ Y ❑ N
6. Noises in or from the jaw joints? ❑ Y ❑ N

7. The following habits are of interest...

1. Thumb / finger / lip sucking until age_____ ❑ Y ❑ N
2. Grinding and / or clenching of teeth ❑ Y ❑ N
3. Tongue thrusting and / or other functional problem ❑ Y ❑ N
4. Snoring, mouth breathing and / or sleep apnea ❑ Y ❑ N
5. Use of bite splint and / or snore aid ❑ Y ❑ N

8. Additional Information

Has your child had a previous orthodontic consultation? ❑ Y ❑ N

Has your child had previous orthodontic treatment? ❑ Y ❑ N

Date:_____

Doctor's Name:_____

City, State:_____

What is the primary problem or your chief concern?_____

_____

What do you expect from orthodontic treatment?_____

Additional comments you would like to make:_____

_____

9. Signature

Signature:_____

Relationship:_____ Date:_____