McNamara Orthodontics

Orthodontic Patient Information and Health History

Welcome to our office. Please fill out both sides.

1. Tell us about yourself...

Name: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr._____

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

Address:_____

City, State, Zip:_____

Home Phone: _____ Cell:_____ Work:_____

Email:_____ Best method to contact you: ❑ Home ❑ Cell ❑ Work ❑ Email

Do you speak English: ❑ Y ❑ N If no, what language do you speak?_____

Occupation:_____ Marital status: ❑ Not married ❑ Married ❑ Divorced ❑ Separated

2. Billing Information

Person 1: Name: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr._____

Address:_____

Phone:_____ Place of Employment:_____

Social Security Number:_____ Date of Birth:_____

Person 2: Name: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. _____

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. Medical History

Have you ever had:

ADD / ADHD ..... ❑ Y ❑ N
Arthritis ..... ❑ Y ❑ N
Asthma / Breathing Difficulties ..... ❑ Y ❑ N
Autism / Asperger's / PPD-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
Osteoporosis / Osteopenia ..... ❑ Y ❑ N
Previous Surgery ..... ❑ Y ❑ N
Thyroid Problems ..... ❑ Y ❑ N
Other (specify)_____ ❑ Y ❑ N

If yes to above, please give details:_____

_____

Do you have allergies (latex, metal, drug, food, etc.)? ❑ Y ❑ N Please specify:_____

Do you require antibiotic pre-medication for dental procedures? ❑ Y ❑ N Use of bisphosphonates now or in the past? ❑ Y ❑ N_____

Have you 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):_____

_____

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4. In case of emergency...

Name:_____

Relationship to you:_____ Phone: _____

5. Dentist and Physician History

Family Dentist:_____ Phone:_____

Address:_____ City, State:_____

Family Physician:_____ Phone:_____

Address:_____ City, State:_____

Referred By:_____

Address:_____ City, State:_____

6. Dental & Temporomandibular Joint History

Have you had any unusual dental experiences? ❑ Y ❑ N

Please specify:_____

_____

_____

Date of last dental visit:_____

Were your teeth cleaned? ❑ Y ❑ N

Have you ever been treated for TMJ ("Jaw Joint") problems? ❑ Y ❑ N

If yes, please describe:_____

_____

_____

7. Do you 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

8. The following are habits 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

9. Additional Information

Have you had a previous orthodontic consultation? ❑ Y ❑ N

Have you had previous orthodontic treatment? ❑ Y ❑ N

Date: _____Doctor's Name:_____ City, State:_____

What is the primary problem or your chief concern?_____

_____

Additional comments you would like to make:_____

_____

10. Signature

Signature: _____ Date: _____