

ORTHODONTIC ASSOCIATES OF MERCER ISLAND

R. William McNeill
DDS • MS

Kara J. McCulloch
DMD • MSD

PATIENT INFORMATION

Date _____

First Name _____ Middle Initial _____ Last Name _____ Nickname _____

Birth date _____ Gender _____ Main Phone _____ Cell/Alternate Phone _____

E-Mail _____ Employer _____ Occupation _____

Address: _____ City: _____ Zip _____

List friends or relatives in the practice _____

Whom may we thank for referring you to our office? _____

List any sports, hobbies or musical instruments played _____

FINANCIAL PARTY INFORMATION (if the information is different from patient)

First Name _____ Last Name _____ Birth Date _____

Address _____ E-mail _____

Main Phone _____ Cell/Alternate Phone _____

Relationship to patient _____ Social Security # _____

ORTHODONTIC INSURANCE INFORMATION

Insurance Co. Name _____ Address _____ Phone _____

Subscriber's Name _____ Subscriber # or SS _____ Birth Date _____

Group # _____ Subscriber's Employer _____ Phone _____

DENTAL HISTORY

Patient's Dentist _____ Phone _____ Date of last cleaning _____

Please describe your orthodontic problem _____

Has the patient had any previous orthodontic treatment? With whom? _____

What concerns you the most about the thought of orthodontic treatment? _____

Please select YES if the patient has had any of the conditions listed below either now or in the past.

YES ___ NO ___ 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 sucking,
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 ___ Any missing or extra permanent teeth?

YES ___ NO ___ Frequent sore throats?

YES ___ NO ___ Apprehensive about dental care?

YES ___ NO ___ Requires premedication?

YES ___ NO ___ Frequently chews gum?

YES ___ NO ___ Ringing in ears?

If any of the above dental questions were answered 'Yes', please explain _____

MEDICAL HISTORY

Patient's Physician _____ Address _____

Phone _____ Date of last Physical _____ Is patient in good health? Yes _____ No _____

List any medications currently being taken by the patient _____

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

Please select YES if the patient has had any of the conditions listed below either now or in the past.

- | | | | |
|----------------|----------------------------------|----------------|--------------------------------|
| YES ___ NO ___ | Rheumatic Fever | YES ___ NO ___ | Cancer |
| YES ___ NO ___ | Tuberculosis/Lung Disease | YES ___ NO ___ | Family History of Cancer |
| YES ___ NO ___ | Pneumonia | YES ___ NO ___ | Received Radiation Therapy |
| YES ___ NO ___ | Liver Disease | YES ___ NO ___ | Growth Problems |
| YES ___ NO ___ | Kidney Disease | YES ___ NO ___ | Endocrine Problems |
| YES ___ NO ___ | Heart Attack/Stroke | YES ___ NO ___ | Hormone Therapy |
| YES ___ NO ___ | Heart Disease | YES ___ NO ___ | Latex/Metal Allergy |
| YES ___ NO ___ | Congenital Heart Defect | YES ___ NO ___ | Nervous Disorders |
| YES ___ NO ___ | Heart Murmur | YES ___ NO ___ | Bone Disorders/Bone Loss |
| YES ___ NO ___ | Hemophilia | YES ___ NO ___ | Diabetes |
| YES ___ NO ___ | Hypertension/High Blood Pressure | YES ___ NO ___ | Seizures/Epilepsy |
| YES ___ NO ___ | Prolonged Bleeding/Transfusion | YES ___ NO ___ | Handicaps/Disabilities |
| YES ___ NO ___ | Anemia | YES ___ NO ___ | Asthma |
| YES ___ NO ___ | HIV/AIDS | YES ___ NO ___ | Arthritis |
| YES ___ NO ___ | Hepatitis | YES ___ NO ___ | Treated for Emotional Problems |
| YES ___ NO ___ | Tonsils/Adenoids Removed | YES ___ NO ___ | Ever Been Hospitalized |

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

If the patient is under the age of 18, please answer the following questions:

Height _____ Weight _____ School _____ Grade _____

Please list the name and birth date of any siblings _____

Father/Guardian 1 name _____

Mother/Guardian 2 name _____

Married _____ Single _____ Separated _____ Divorced _____ (if so, which parent does child live with?) _____

YES ___ NO ___ If patient is a girl, has menstruation begun? (if so, when? _____)

YES ___ NO ___ If patient is a boy, has their voice changed?

YES ___ NO ___ Has the patient grown in the past year or has their shoe size changed recently?

YES ___ NO ___ Patient interested in treatment?

YES ___ NO ___ Has either biological parent ever had orthodontic treatment?

Signature: _____ Date: _____