macdonald orthodontics
www.macdonaldortho.com

Date: _____

1. PATIENT INFORMATION

Name _____ Sex _____ Phone _____ Birthday _____ Age _____

Address _____ City _____ State _____ Zip _____

2. RESPONSIBLE PARTY INFORMATION

Please Check:

☐ **SELF** ☐ **FATHER** ☐ **STEPFATHER** ☐ **GUARDIAN:**

Name _____
FIRST MI LAST

Address _____

City_____ State_____ Zip_____

Home Phone_____Work _____

Cell Phone_____ SSN _____

Email Address _____

Birthday_____ Age_____ Sex_____ Marital Status _____

How long at this address? _____ How long at previous address?_____

EMPLOYER INFORMATION

Employer Name _____

No. of Years Employed _____

☐ **SPOUSE** ☐ **MOTHER** ☐ **STEPMOTHER** ☐ **GUARDIAN:**

Name _____
FIRST MI LAST

Address _____

City_____ State_____ Zip_____

Home Phone_____Work _____

Cell Phone_____ SSN _____

Email Address _____

Birthday_____ Age_____ Sex_____ Marital Status _____

How long at this address? _____ How long at previous address?_____

EMPLOYER INFORMATION

Employer Name _____

No. of Years Employed _____

3. PRIMARY ORTHODONTIC INSURANCE

Insurance Co Name: _____

Insurance Co Phone #: _____

Insurance Co Address: _____

_____
City State Zip

ID#_____ Group # _____

Insured's Name: _____

Insured's Address: _____

_____
City State Zip

Insured's Birthdate: ____-____-____ Relation to patient: _____

Insured's SSN:_____

Insured's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Insurance Co Name: _____

Insurance Co Phone #: _____

Insurance Co Address: _____

_____
City State Zip

ID#_____ Group # _____

Insured's Name: _____

Insured's Address: _____

_____
City State Zip

Insured's Birthdate: ____-____-____ Relation to patient: _____

Insured's SSN:_____

Insured's Employer: _____

4. INFORMATION

Other Children _____ Age_____

_____ Age_____

_____ Age_____

_____ Age_____

Dentist Name_____

Who may we thank for referring you?_____

School Name _____ Grade _____

Sports or Hobbies _____

Dental related history

What would you like orthodontic treatment to accomplish?

_____

Y N Have you ever been evaluated for orthodontic treatment?

Y N Have you had orthodontic treatment?

Y N Have you been informed of any missing or extra permanent teeth?

Y N Have there been any injuries to your head, neck, jaw or teeth?
If yes – please explain: _____

Y N Have your wisdom teeth been extracted?

Y N Do you have bleeding and / or inflammation of the gums?

Y N Do you have difficulty chewing food or opening wide?

Y N Do you have difficulty breathing through your nose?

Y N Have adenoids or tonsils been removed?

Y N Have you ever had pain / tenderness in your jaw joints (TMJ / TMD), or muscles of the face or neck?

Y N Do your jaw joints pop, click or make noises?

Have you ever had any of the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Hearing impairment
Y	N	Anemia	Y	N	Hepatitis
Y	N	Arthritis	Y	N	High Blood Pressure
Y	N	Artificial Bones / Joints	Y	N	HIV+ / AIDS
Y	N	Asthma	Y	N	Liver Disease
Y	N	Cancer / Chemotherapy	Y	N	Low Blood Pressure
Y	N	Congenital Heart Defect	Y	N	Lupus
Y	N	Convulsions/ Epilepsy	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Osteopenia / Osteoporosis
Y	N	Handicaps / Disabilities	Y	N	Rheumatic / Scarlet Fever
Y	N	Heart Attack	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur			

Please discuss any medical problems that you have had:

_____

_____

Y N Latex Allergy Y N Metal Allergy

Please list any disease, condition, or allergy not listed:

_____

_____

Y N Are you being treated by a physician for any condition at the present time?
If yes – please explain: _____

Y N Have you taken any medication or drugs in the last six weeks?
If yes – please list: _____

Y N (Females only) Are you pregnant? How many weeks? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held to the strictest confidence and it is my responsibility to inform this office of any changes.

I authorize the dental staff to perform the necessary dental services that have been recommended.

_____

Signature Date

I understand that if I should choose to proceed with treatment, I am responsible for payment of services rendered. If applicable any insurance that is not covered is my sole responsibility. I herby authorize payment of any insurance benefit directly to Macdonald Orthodontics.

_____

Signature Date

This office reserves the right to verify the credit status of parents of patients who have been extended in house payment options should they become delinquent on their account.

_____

Signature Date

Doctor Notes:

_____

_____

_____

_____

_____