McCABE ORTHODONTICS

Please bring in this completed form to your appointment.

WE LOOK FORWARD TO YOUR VISIT!

PATIENT INFORMATION

Patient's Name:	**Preferred Name:**	Today's Date:
Sex: € Male € Female	Date of Birth:	Age:
Social Security Number:		Home Phone:
Home Address: City/Sate/Zip		Cell Phone:
		Email Address:
Employer:		Work Phone:
Whom may we thank for referring you:		General Dentist:
Please list other family members treated here:		

SPOUSE INFORMATION

Spouse's Name:	Date of Birth:
Home Address: *(if different from patient)*	Home Phone:
	Email Address:
Social Security Number:	Occupation:
Employer:	Work Phone:

DENTAL/ALLERGY HISTORY

Date of last dental visit:	Purpose of last visit:
What are the main concerns that you would like orthodontics to correct?	
Have you been evaluated for orthodontic treatment before?	€ Yes € No
Have you had any injuries to the face, mouth or chin?	€ Yes € No
Have you been informed of any missing or extra permanent teeth?	€ Yes € No
Have you had any pain/tenderness in his/her jaw joint (TMJ/TMD)?	€ Yes € No
Have you had a serious/difficult problem associated with any previous dental work?	€ Yes € No
Do you have any speech problems?	€ Yes € No
Do you generally breathe through your mouth while sleeping?	€ Yes € No
Do you generally breathe through your mouth while awake?	€ Yes € No
Do your gums ever bleed?	€ Yes € No
Do you smoke or use tobacco in any form?	€ Yes € No
Do you like your smile?	€ Yes € No
How would you describe your current dental health?	€ Good € Fair € Poor

ALLERGIES

Do you have any of the following allergies?

Aspirin	€ Yes € No	Latex	€ Yes € No
Codeine	€ Yes € No	Metals	€ Yes € No
Dental Anesthetics	€ Yes € No	Penicillin	€ Yes € No
Erythromycin	€ Yes € No	Tetracycline	€ Yes € No

Other Allergies:

HANDICAPS/DISABILITIES:

More IMPORTANT details need to be completed on the back of this form. Thank you!

For Office Use ONLY	**Patient I.D. #**

MEDICAL HISTORY

Patient's Physician:	Phone Number:	Date of Last Visit:
Emergency Contact:	Phone Number:	Relationship:

MEDICAL CONDITIONS

Have you ever had any of these medical conditions?

Abnormal Bleeding	€ Yes € No	Heart Disease	€ Yes € No
ADD/ADHD	€ Yes € No	Heart Murmur	€ Yes € No
AIDS/HIV	€ Yes € No	Hemophilia	€ Yes € No
Anemia/Radiation Treatment	€ Yes € No	Hepatitis (€ A € B € C)	€ Yes € No
Artificial Bone/Joints/Valves	€ Yes € No	High/Low Blood Pressure	€ Yes € No
Arthritis	€ Yes € No	Kidney/Liver Problems	€ Yes € No
Asthma	€ Yes € No	Measles/Mumps	€ Yes € No
Cancer/Leukemia	€ Yes € No	Mitral Valve Prolapse	€ Yes € No
Cerebral Palsy	€ Yes € No	Mononucleosis	€ Yes € No
Congenital Heart Defects	€ Yes € No	Pregnant (currently)	€ Yes € No
Diabetes	€ Yes € No	Psychiatric Problems	€ Yes € No
Drug/Alcohol Abuse	€ Yes € No	Rheumatic/Scarlet Fever	€ Yes € No
Fever Blisters	€ Yes € No	Sinus Problems	€ Yes € No
Hearing Impairment	€ Yes € No	Thyroid Disease	€ Yes € No
Heart Attack/Problems	€ Yes € No	Tuberculosis (TB)	€ Yes € No

Please discuss any medical problems you have had:

Please list any current medications being used and the reason for each:

RESPONSIBLE PARTY INFORMATION – *complete only if different from patient*

Person Financially Responsible:	Date of Birth:
Relationship to Patient:	Social Security Number:
Billing Address:	Home Phone:
	Email Address:
Employer:	Work Phone:

INSURANCE INFORMATION

Do you have orthodontic coverage? € Yes € No	Employer:	
Insurance Company:	Insured's Name:	
Insurance Claims Address:	Insured's Date of Birth:	
	I.D.#	Group #
Insurance Company Phone:	Social Security # (required):	

Financial Information/ Signature Requirement

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and/or deductibles that my insurance does not cover.

Signature of Patient/Responsible Party **Date**

This office reserves the right to verify credit of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of Patient/Responsible Party **Date**

Treatment Authorization Signature Requirement

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform and necessary dental services I may need during diagnosis and treatment.

Signature of Patient **Date**

For Office Use ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Doctor' Comments:

Doctor's Initials: **Date:**