# Welcome to McKenna Orthodontics

The benefits of a happy, healthy smile are immeasurable. Everyone should love to smile. Please fill out this form completely. The better we communicate, ***the better we can care for you.***

**Date:** ________________________ **School:** ______________________

**Patient Name:** ______________________________________________________________________
(First) (Middle) (Last) (Preferred)

**Birthday:** ______/______/___________ **Age:** __________ ☐ Male ☐ Female

**General Dentist:** _____________ Last Visit Date: _______________ Treatment Rendered: ___________

## Responsible Party

**Name:** ____________________________________________________________________________
(First) (Middle) (Last)

**Cell Phone #:** _____-_____-_____ OK TO TEXT? Y N Alternate **Phone #:** _____-_____-_____

**Address:** __________________________________________________________________________
(City) (State) (Zip)

**SS#:** ________-________-________ **Email Address:** ______________________________________

**DL#** ____________________ **Employer:** _____________________________________________

**Employer Address:** _____________________ **Occupation:** ______________ **Time at Job:** _________

**Spouse Name:** _____________________Birthdate: ____/____/____ **SS#** ______-_______-_________

## Insurance Information

**Orthodontic Coverage?** Yes No **Insurance Company:** _________________________________________

**Insurance Co Address:** ___________________________ **Phone #:** _______-________-________

**Insured Name:** _____________________ **Group # (Plan, Local, Policy):** __________________________

**Relationship to Patient:** _________________________________ **Insured Birthdate:** _____/_____/_____

**Insured SS#** _____-_____-_____ **Insured Employer:** _________________ **Secondary Ins?** *Please Provide Card*

## Emergency Contact Information

**Name:** __________________________________________ **Relationship:** ______________________

**Phone #:** __________-__________-___________ **Alt.Phone #:** _________-_________-_________

**How did you hear about us?** Referral (Who can we thank? ______________________________)
Social Media Google Other: _____________________

## Medical History

**Do you have a personal physician?** Yes No **Physician's Name:** ____________________

**Physician Phone #:** ______-______-______ **Current Health:** Good Fair Poor

**Are you currently under the care of a physician?** Yes No **Explain:** ____________________

**Are you taking any prescription/over the counter drugs?** Yes No **List:** ____________________

**Are you taking birth control?** Yes No **Are you pregnant?** Yes No **Are you nursing?** Yes No

**Have you ever had any of the following diseases or medical problems:**

| | | | | | |
|---|---|---|---|---|---|
| **Anemia/Radiation** | Yes | No | **Heart Surgery/Treatment Pacemaker** | Yes | No |
| **Artificial Bones/Joints** | Yes | No | **Hemophilia/Abnormal Bleeding** | Yes | No |
| **Artificial Valves** | Yes | No | **Hepatitis** | Yes | No |
| **Asthma Arthritis** | Yes | No | **High/Low Blood Pressure** | Yes | No |
| **Blood Transfusion** | Yes | No | **HIV +/AIDS** | Yes | No |
| **Cancer/Chemotherapy** | Yes | No | **Hospitalized for Any Reason** | Yes | No |
| **Congenital Heart Defect** | Yes | No | **Kidney Problems** | Yes | No |
| **Diabetes/Tuberculosis** | Yes | No | **Mitral Valve Prolapse** | Yes | No |
| **Difficulty Breathing** | Yes | No | **Psychiatric Problems** | Yes | No |
| **Drug/Alcohol Abuse** | Yes | No | **Rheumatic/Scarlet Fever** | Yes | No |
| **Emphysema/Glaucoma** | Yes | No | **Severe/Frequent Headaches** | Yes | No |
| **Epilepsy/Seizure/Fainting** | Yes | No | **Shingles Spells** | Yes | No |
| **Fever Blisters/Herpes** | Yes | No | **Sinus Problems** | Yes | No |
| **Heart Attach/Stroke** | Yes | No | **Ulcers/Colitis** | Yes | No |
| **Heart Murmur** | Yes | No | **Veneral Disease** | Yes | No |

**Please list any serious medical condition(s):** ____________________

Are you allergic to any of the following? Aspirin: Yes No Dental Anesthetics: Yes No
Penicillin: Yes No Codeine: Yes No Any Metal/Plastic: Yes No Latex: Yes No

## Dental History

What are the main concerns that you would like orthodontics to accomplish? ____________________
Have you ever been evaluated for orthodontic treatment? Yes No
Have you ever had a serious/difficult problem associated with any previous dental work? Yes No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Yes No
Your current dental health is: Good Fair Poor
Do you like your smile? Yes No
Do your gums bleed? Yes No
Have you ever had an injury to your: Mouth Teeth Chin
Do you have any speech problems? Yes No
Do you have any missing or extra permanent teeth? Yes No
Do you generally breathe through your mouth? Yes No Awake? Yes No Asleep? Yes No

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. ____________ (Initial)**

**This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extendingcredit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.** ____________________

**(Signature)** **(Date)**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.
OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the patient named herein. Initials: __________ Date: __________
Doctor's Comments: ____________________