McConnell ORTHODONTICS

changing smiles changing lives

PATIENT INFORMATION – ADULT

Patient Name (first, middle, last)_____

Nickname (if preferred)_____ ❑ Male ❑ Female Date of Birth _____

Home Phone_____ Work_____ Cell _____

Address _____ City/State/Zip _____

Email_____ (will not be shared with third parties)

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Current General Dentist _____ How long since your last dental visit? _____

What are your primary goals for orthodontic treatment: _____

Have you visited an orthodontist before? ❑ Yes ❑ No If Yes, name _____

Have we treated a friend or another member of your family? ❑ Yes ❑ No If Yes, name(s) _____

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

Is there anything that you would like to discuss with Dr. McConnell in private? ❑ Yes ❑ No

INSURANCE INFORMATION

If you have an insurance card, we would be happy to make a copy and complete this information for you.

Insured's Name _____ Insured's Employer _____

Insured's Social Security No. _____ Insured's Date of Birth _____

Insurance Company _____ Insurance Company's Phone _____

Insurance Company's Address_____

Group # _____ Policy # _____

Do you have secondary coverage? ❑ Yes ❑ No If Yes, please complete.

Insured's Name _____ Insured's Employer _____

Insured's Social Security No. _____ Insured's Date of Birth _____

Insurance Company _____ Insurance Company's Phone _____

Insurance Company's Address_____

Group # _____ Policy # _____

MEDICAL HISTORY

Please circle **Y (Yes) or N (No)** for the following questions. Your answers are for **our records only** and will be kept strictly confidential. Please use the space after the question or on the back of the form for additional explanation, if necessary.

Medical History

Y N Are you in good general health?

Y N Has there been any change in your general health within the last year?

Y N Last Physical Exam (month/year): _____

Y N Are you currently under the care of a physician? If so, what is being treated? _____

Y N Have you had a serious illness/hospitalization in the past 5 years? If so, for what? _____

Y N Are you taking any medication (include non-prescription)? _____

Do you have any of the following conditions, allergies, or drug reactions to:

Y N Latex

Y N Penicillin, Sulfa Drugs, or other antibiotics

Y N Nickel or other metals

Y N Aspirin, Ibuprofen, Tylenol

Y N Local Anesthetics

Y N Codeine or other narcotics

Y N Other _____

Y N Respiratory Problems, Emphysema

Y N Asthma or Hay Fever

Y N Sinus Trouble

Y N Persistent Swollen Neck Glands

Y N Thyroid or Endocrine Problems

Y N Low Blood Pressure

Y N Cardiovascular Disease (Heart Trouble, Heart Attack, Angina, High Blood Pressure, Arteriosclerosis, Stroke)

Y N Damaged or Artificial Heart Valves, including Heart Murmur or Rheumatic Heart Disease

Y N Do you require antibiotic pre-medication prior to dental visits?

Y N Arthritis, Joint Problems or artificial joints/limbs

Y N Birth Defects

Y N Kidney Trouble

Y N Tuberculosis

Y N Bone Fractures or trauma to face or jaw

(over)

Y N Diabetes
Y N Hepatitis, Jaundice or Liver Disease
Y N AIDS or HIV infection
Y N Sexually Transmitted Disease
Y N Substance Abuse Problem (past or present)
Y N Mental Health Problem or Nervous Disorder
Y N Fainting Spells or Seizures
Y N Epilepsy or other neurological disease
Y N Blood Disorder such as Anemia
Y N Abnormal Bleeding or Blood Transfusion
Y N Vision, Hearing or Speech Difficulty
Y N Persistent Cough
Y N Frequent Colds or Sore Throats
Y N Frequent Headaches
Y N Stomach Ulcer or Hyperacidity
Y N Tumor (Cancerous or Benign)
Y N Radiation Therapy or Chemotherapy
Y N Tonsils or Adenoids removed? What age? _____
Y N ***Females:*** Are you pregnant?

Y N Have you ever taken Bisphosphonates or other Osteoporosis medication?
Y N Do you have any disease, condition or problem not listed above that you think we should know about?
If so, please explain_____

DENTAL HISTORY

Dental History

Y N Chipped or Injured Permanent Teeth
Y N Teeth Sensitive to hot or cold
Y N Jaw Fractures, Cyst, Mouth Infections
Y N Previous Root Canal Therapy
Y N Bleeding Gums or Bad Taste/Mouth Odor
Y N Other Periodontal (gum) problems
Y N Problems with Food Trapped between teeth
Y N Frequent Canker Sores or Cold Sores
Y N Mouth Breathing habit or Snoring troubles
Y N Abnormal Swallowing (Tongue Thrust)
Y N Have you had a negative dental experience?
Y N History of Missing or Extra Teeth
Y N Have any permanent teeth been removed?
Y N Have Wisdom Teeth been removed?
Y N Teeth that irritate tongue, cheek, lip, etc.
Y N Previous Orthodontic treatment or retainer
Y N Previous Periodontal (gum) treatment
Y N Numerous Fillings
Y N Damaged Restorations or Fillings
Y N Thumb or Finger Sucking habit as a child
Y N Loose or Shifting Teeth
Y N Is all dental work completed at this time?

TMJ History

Y N Have you had a TMJ screening?
Y N Do you have a history of jaw joint problems?
Y N Have you been treated for "TMJ"?
Y N Does your bite feel uncomfortable or unusual?
Y N Do you grind your teeth?
Y N Do you clench your teeth?
Y N Has your jaw ever locked open or closed?
Y N Do you have pain in your jaw joint?
Y N Have you experienced soreness in the muscles of your face or around the ears?
Y N Have you noticed clicking or popping in your jaw joint?
Y N Do you have difficulty chewing or opening your mouth?

Symptoms – If experiencing pain or discomfort, please be specific about location; circle R (right) or L (left) side or both if they apply.

❑ In front of ears	R	L	❑ Temples	R	L	❑ Jaw Joints	R	L	❑ My Teeth		
❑ Below ears	R	L	❑ Above ears	R	L	❑ Eyes	R	L	❑ Sinuses		
❑ Neck	R	L	❑ In ears	R	L	❑ Shoulders	R	L	❑ Other _____		

Patient Motivation for Orthodontic Treatment

Patients and their general dentists often request changes in bites or facial features. Please help us to understand your concerns by completing the following information; please be specific (circle the words more, less, forward, etc.) **If you don't have any specific requests, you may omit this section.**

Teeth – If your teeth could be changed, how would you like them to change?

❑ Straighten the front teeth.....	Upper	Lower	❑ Eliminate crowding of teeth.....	Upper	Lower
❑ Straighten the back teeth.....	Upper	Lower	❑ Eliminate spaces between teeth	Upper	Lower
❑ Move Upper Teeth.....	Forward	Backward	❑ Make the line of upper teeth more level		
❑ Move lower teeth.....	Forward	Backward	❑ Other _____		

Face – If your facial appearance could be changed, what would you change?

❑ Move upper lip.....	Forward	Backward	❑ Move chin	Forward	Backward
❑ Move lower lip	Forward	Backward	❑ Move chin	Left	Right
❑ Teeth shown when smiling.....	More	Less	❑ Gums shown when smiling	More	Less

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made. If there are any changes later to this history record or medical or dental status, I will inform the practice.

Signature _____ Date _____