History

PATIENT INFORMATION

First Name:_____ Last Name:_____ Preferred Name:_____ Sex:_____

Birthdate:_____ Age:_____ Home Number:_____ Cell Phone:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Social Security #_____ Fax:_____

School (if student)_____ Grade:_____

Employed by/ Occupation:_____ Business Phone:_____

Person responsible for account:_____ Relationship to patient:_____

How would you prefer to receive appointment reminders? (circle one) EMAIL TEXT

How did you hear about our office? Please list all that apply: (circle one)

DENTIST PATIENT INSURANCE INTERNET BILLBOARD Other:_____

Related patients or friends that are or have ever been under our care:_____

Name and age of siblings:_____

PARENT INFORMATION Please complete if patient is a minor.

Father's Name/Guardian:_____

Address:_____

City:_____ State:___ Zip:_____

SS#:_____ Bdate:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Employer:_____

Email:_____

PARENT INFORMATION Please complete if patient is a minor.

Mother's Name/Guardian:_____

Address:_____

City:_____ State:___ Zip:_____

SS#:_____ Bdate:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Employer:_____

Email:_____

If divorce is involved, who is the custodial parent?_____

May patient information be released to the non-custodial parent? (circle one) YES NO

INSURANCE INFORMATION

Primary Insurance Company:_____ Phone Number_____

Insured's Name:_____ Insured's DOB_____ Insured's SSN:_____

ID Number:_____ Relationship to Patient:_____

Insured's Employer:_____ Group Number:_____

Secondary Insurance Company:_____ Phone Number_____

Insured's Name:_____ Insured's DOB_____ Insured's SSN:_____

ID Number:_____ Relationship to Patient:_____

Insured's Employer:_____ Group Number:_____

Over

History

PATIENT MEDICAL HISTORY Please check if patient has or has had:

- o Heart Murmur
- o Mitral Valve Prolapse
- o Heart Disease/Disorder
- o High Blood Pressure
- o Low Blood Pressure
- o Bone Disorder
- o Joint Replacement or Implants
- o Anemia/Blood Disorders
- o Prolonged Bleeding
- o Rheumatic Fever
- o Arthritis
- o Immune System Problems
- o Recent Weight Gain or Loss
- o HIV/AIDS
- o STD
- o Hepatitis or Liver Disease
- o Kidney Disease
- o Diabetes
- o Tumors/Growths
- o Cancer Treatment
- o Tonsils or Adenoids Removed
- o Tonsillitis
- o Earaches
- o Sinus Trouble
- o Asthma/Hay Fever
- o Respiratory Problems
- o Thyroid/Parathyroid Problems
- o Brain Injury
- o Seizures
- o Fainting/Dizziness
- o Emotional Problems
- o Psychiatric Care
- o Glaucoma

Are you allergic to or have you had any reactions to the following?

- o Local Anesthetics (e.g. Novocain)
- o Penicillin or other Antibiotics
- o Sulfa Drugs
- o Any Metals (e.g. nickel, mercury, etc.)
- o Latex Rubber
- o Other (please list below)

List any other Illnesses:_____

List any drugs or medications now being taken:_____

Is patient presently under a physician's care? YES NO Reason if Yes:_____

Have you ever been told to pre-medicate before dental appointments? YES NO Reason if Yes:_____

Name of Physician:_____

PATIENT DENTAL HISTORY

Name of Dentist:_____ Date of last visit:_____

What concerns you most about your teeth?_____

Do you have any type of thumb or tongue habit?_____

Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____

Are you aware of your jaw clicking or popping?_____

AUTHORIZATION AND RELEASE

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of all medical records on the above named patient to the referring dentist, physician or other health care provider, as well as information and records necessary for processing insurance claims. I authorize the release of financial information for collection and records transfer purposes. I authorize the necessary diagnostic tests and any orthodontic treatment deemed necessary to be performed by or under the direction of Dr. McKinney and/or associates of McKinney Orthodontics. I give my permission for any photographs, x-rays or study models to be updated during treatment and to be used for displays in our office, on our website, at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I hereby authorize the necessary credit information to be obtained by McKinney Orthodontics or other third party company for the purposes of consideration of payment options. We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic account. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Signature:_____ Relationship to Patient:_____ Date:_____