McGRADY ORTHODONTICS

FOR ADULTS: WELCOME TO OUR PRACTICE

1. ABOUT YOU

Today's date: _____ Age: _____ DOB: _____

☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Name: _____

Last First Middle

I prefer to be called: _____

Home#: _____ Cell#: _____

DL#: _____ Work#: _____

SS#: _____

Home Address:

_____

_____

City State Zip

2. ABOUT YOUR EMPLOYER

Name: _____

Address: _____

_____

How long you have worked there? _____

Occupation: _____

When & where are the best times to reach you? _____

_____

Other family members seen by us: _____

_____

Whom may we THANK for referring you? _____

3. SPOUSE INFORMATION

Name: _____

Employer: _____

WK#: _____ DL#: _____

SS#: _____

DOB: _____

4. DENTAL INFORMATION

Previous / Present Dentist: _____

Street: _____

Phone#: _____ Last Visit: _____

5. RESPONSIBLE PARTY INFO

Name: _____

Billing address : _____

_____

City State Zip

WK#: _____ Home#: _____

Cell#: _____ Email: _____

Employer: _____

SS#: _____ DL#: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____

WK#: _____ Home#: _____

Cell#: _____

6. PRIMARY DENTAL INSURANCE

Ins. Name: _____

Ins. address : _____

_____

Insurance Co. Phone #: _____

Group/Policy # : _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage ☐ Yes ☐ No

7. SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. address : _____

_____

Insurance Co. Phone #: _____

Group/Policy # : _____

_____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage ☐ Yes ☐ No

8. DENTAL HISTORY

Why have you come to the Orthodontist today? : _____

Are you currently in pain? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had any serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Have you ever had pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Types of bristles: ☐ Hard ☐ Medium ☐ Soft

9. MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Name: _____

Phone #: _____ Last Visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a doctor? ☐ Yes ☐ No

Explain: _____

Are you taking any prescription drugs? ☐ Yes ☐ No

List: _____

FOR WOMEN ONLY:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week#: _____

Are you nursing? ☐ Yes ☐ No

10. HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Prothesis	☐	☐	History of Scarlet Fever
☐	☐	Heart attack	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Artificial valves
☐	☐	HIV+/AIDS	☐	☐	Heart surgery/pacmkr
☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Mitral valve prolapse
☐	☐	Tuberculosis	☐	☐	Artificial bones / joints
☐	☐	Shingles	☐	☐	Sev./freq. headaches
☐	☐	Fever Blister	☐	☐	Hi / low blood pressure
☐	☐	Venereal Disease	☐	☐	Drug / alcohol abuse
☐	☐	Ulcers / colitis	☐	☐	Blood transfusion
☐	☐	Heart murmur	☐	☐	Anemia/Radiation tx
☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Sinus problems	☐	☐	Difficulty Breathing
☐	☐	Other _____			

11. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Erythromycin
☐	☐	Codeine	☐	☐	Dental Anesthetics
☐	☐	Latex	☐	☐	Metal
☐	☐	Penicillin	☐	☐	Other _____

Our office Is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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

Signature _____ Date:_____

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

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

Initials: _____ Date:_____

Doctor 's comments:_____

_____

Medical History Update:

1. Date:_____ Signature:_____

Comments:_____

1. Date:_____ Signature:_____

Comments:_____