(This information is necessary for our files and will be considered confidential)

Changing Lives... One Smile at a Time

TIMOTHY J. MCREATH DDS MS

SPECIALIST IN ORTHODONTICS

DATE____________________

PATIENT INFORMATION

Name (first/middle/last)______________________________
Nickname______________________ Phone____________________
Birthdate__________________ Age __________ ☐ Male ☐ Female
Address (street/city/state/zip)______________________________
____
____
Dentist______________________________
Parent/guardian name (if minor)______________________________
Hobbies & interests______________________________
____
____
____

RESPONSIBLE PARTY INFORMATION

Name (first/middle/last)______________________________
Marital status______________________________
Residence (street/city/state/zip)______________________________
____
____
Mailing address (street/city/state/zip)______________________________
____
____
How long at this address______________________________
Home phone__________________ Work phone __________________
Previous address (if less than 3 yrs)______________________________
____
____
Social Security #______________________________
Birthdate__________________ Relationship to patient __________
Employer______________________________
Occupation____________________ # of yrs employed__________

(SPOUSE INFORMATION)

Name (first/middle/last)______________________________
Social Security #______________________________
Birthdate__________________ Relationship to patient __________
Employer______________________________
Occupation____________________ # of yrs employed__________

ORTHODONTIC INSURANCE INFORMATION

Insured's name (first/middle/last)______________________________
Birthdate__________________ Social Security #________________
Relationship to patient______________ Work phone______________
Insurance company______________________________
Group #__________________ Local #__________________
Insurance co. address (street/city/state/zip)______________________________
____
____
Insurance co. phone______________________________
Employer name______________________________
Employer address (street/city/state/zip)______________________________
____
____

Do you have other orthodontic coverage? ☐ Yes ☐ No

Insured's name (first/middle/last)______________________________
Birthdate__________________ Social Security #________________
Relationship to patient______________ Work phone______________
Insurance company______________________________
Group #__________________ Local #__________________
Insurance co. address (street/city/state/zip)______________________________
____
Insurance co. phone______________________________
Employer name______________________________
Employer address (street/city/state/zip)______________________________
____
____
Additional diagnostic letters sent to______________________________
Relationship______________________________
Address (street/city/state/zip)______________________________
____

EMERGENCY INFORMATION

Name of nearest relative not living with you______________________________
Address (street/city/state/zip)______________________________
____
Phone______________________________

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (parent's signature if minor)______________________________
Updates (date & initial)__________ __________ __________ __________ __________

(PLEASE COMPLETE REVERSE SIDE)

www.DRMCREATH.com | info@DRMCREATH.com
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OFFICE: 2625 NEW PINERY RD | MAIL: PO BOX 342 | PORTAGE, WI 53901 | P: (608) 742-4800 | F: (608) 745-5727

Health Questionnaire

Name of physician________________________________ City________________________________

Health History (check boxes that apply)

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Circulatory problems
- ☐ Rheumatic fever
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Radiation treatments
- ☐ Nervous problems
- ☐ Tuberculosis
- ☐ Excessive bleeding
- ☐ Cerebral palsy
- ☐ Scarlet fever
- ☐ Malignancies
- ☐ Chronic sinus
- ☐ Chronic ear problems
- ☐ Anemia
- ☐ Arthritis
- ☐ Adenoids removed
- ☐ AIDS
- ☐ TMJ
- ☐ Venereal disease/herpes
- ☐ Unexplained weight loss
- ☐ Persistent cough (2-3 wks)
- ☐ Bloody cough
- ☐ Night sweats

Allergies (check boxes that apply)

- ☐ Penicillin
- ☐ Latex
- ☐ Local anesthetic (ie Novocaine)
- ☐ Nickel
- ☐ Codeine
- ☐ Other________________

Are you pregnant? ☐ Yes ☐ No

(If yes) How many months?________________________

Please list all medications currently being taken________________

____

____

____

Please list any other medical conditions you feel Dr. McReath should be aware of________________________________

____

____

Have you been hospitalized in the last two years? ☐ Yes ☐ No

(If yes) Please explain________________________________

____

____

Dental Health

Dentist's name________________________________

City________________________________

Date of last visit________________________________

Have you had any injuries to the mouth/jaw area? ☐ Yes ☐ No

(If yes) Please explain________________________________

When were your last given dental x-rays?________________________

Is this the first orthodontic visit? ☐ Yes ☐ No

Have you been diagnosed with periodontal disease? ☐ Yes ☐ No

(If yes) Please list the type of treatment for it ________________

Have you been told you are missing any adult teeth? ☐ Yes ☐ No

Have you been told you have TMJ?

(If yes) Please list type of treatment for it________________

Any pain or clicking when opening the mouth? ☐ Yes ☐ No

Has the dentist indicated an orthodontic problem? ☐ Yes ☐ No

(If yes) What specifically?________________________

Please list any experiences/problems you would like Dr. McReath to be aware of________________________________

____

____

If patient is a child (check boxes that apply)

- ☐ Thumb sucking
- ☐ Tongue thrusting
- ☐ Mouth breathing

How did you hear about us? (check boxes that apply)

- ☐ Dentist
- ☐ Family member
- ☐ Promotional item
- ☐ Friend
- ☐ Web site

Whom may we thank for referring you?________________________

Other family members/friends seen by us________________________

____

Has the patient had a previous orthodontic consultation? ☐ Yes ☐ No

Release (initials and signature needed)

____I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

____I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

____I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

____I understand that I am responsible for all costs of dental treatment.

Signature of responsible party____

Relationship________________________________ Date________________________________