Date _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____ ❑ Own ❑ Rent
Street City State Zip

Mailing Address _____ Email _____
Street City State Zip

How long at this address _____ Previous Address _____
(if less than 3 yrs) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Insurance Information

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? ❑ Yes ❑ No If yes: _____

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

CONFIDENTIAL (for record and pretreatment evaluation)

HEALTH QUESTIONNAIRE

Name of Physician _____ City _____

Health History

(check boxes that apply)

- ❑ Heart problems
- ❑ High blood pressure
- ❑ Circulatory problems
- ❑ Hepatitis
- ❑ Diabetes
- ❑ Radiation treatments
- ❑ Liver problems
- ❑ Nervous problems
- ❑ Tuberculosis
- ❑ Excessive bleeding
- ❑ Malignancies
- ❑ Chronic sinus problems
- ❑ Chronic ear problems
- ❑ Arthritis
- ❑ Adenoids/tonsils removed
- ❑ H.I.V.
- ❑ Venereal disease/Herpes
- ❑ A.D.H.D/A.D.D.
- ❑ Autism
- ❑ Eating disorder
- ❑ Seizures
- ❑ Prosthetic joints

Allergies

(check boxes that apply)

❑ Penicillin ❑ Latex ❑ Nickel ❑ Local Anesthetic (i.e. Novocaine)

❑ 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 Information

Name of Dentist _____ City _____ Date of last visit _____

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

If yes, please explain: _____

Is this the first orthodontic visit? ❑ Yes ❑ No

Has the dentist pointed to an orthodontic problem? ❑ Yes ❑ No

If yes, please explain: _____

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

Do you have any pain or clicking when opening your mouth? ❑ Yes ❑ No

If yes, please describe your symptoms: _____

_____

What would you like to change about your teeth/smile? _____

_____

If the patient is a child...

❑ Thumb Sucking ❑ Tongue Thrusting ❑ Mouth Breathing

Release:

I authorize the dentist to preform 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