

Garland McKelvain, D.D.S., M.S.D., INC.
SPECIALIST IN ORTHODONTICS

ABOUT THE PATIENT:

Date: _____

Patient's Name: (First) _____ (Last) _____ (MI) _____

Nickname: _____

Birth date: ____ - ____ - ____ Age: _____

Address: _____, _____
(Street) (City) (State) (Zip)

Telephone Number: ____ - ____ - ____

Whom may we thank for referring you? _____

Have we treated any of your family members? _____

General Dentist: _____ Last visit: _____

PATIENT WORK / INSURANCE INFORMATION

Name: _____ Home Telephone Number: ____ - ____ - ____

Employer: _____ Work Telephone Number: ____ - ____ - ____

S.S. Number: ____ - ____ - ____ Birth date: ____ - ____ - ____

Orthodontic coverage: Yes ____ No ____

Insurance Company Name: _____ Telephone # ____ - ____ - ____

SPOUSE'S WORK / INSURANCE INFORMATION

Name: _____ Home Telephone Number: ____ - ____ - ____

Employer: _____ Work Telephone Number: ____ - ____ - ____

S.S. Number: ____ - ____ - ____ Birth date: ____ - ____ - ____

Orthodontic coverage: Yes ____ No ____

Insurance Company Name: _____ Telephone # ____ - ____ - ____

(PLEASE COMPLETE OTHER SIDE OF FORM)

What are the main concerns that you would like orthodontics to accomplish?

Please answer yes or no to the following:

Have you ever been evaluated for or had orthodontics before? _____

Have there been any injuries to the face, mouth, teeth, or chin? _____

Have adenoids or tonsils been removed? _____

Have you been informed of any missing or extra permanent teeth? _____

Have you had any pain or tenderness in your jaw bone joint? _____

Have you ever been told by physician to take antibiotics before dental procedures? _____

Are you pregnant? _____

Your physician: _____ Telephone # _____ - _____ - _____

Approximate date of last visit: _____

Are you currently under the care of a physician? Yes No

Please describe your current physical health: Good Fair Poor

Please list any drugs that you are currently taking: _____

Please list all drugs that you are allergic to: _____

Have you had any of the following medical problems:

Y	N	Abnormal bleeding	Y	N	Diabetes
Y	N	Allergies to any drugs	Y	N	Handicaps/Disabilities
Y	N	Allergies to Latex, Metals, Plastics	Y	N	Hearing Impairment
Y	N	Any hospital stays	Y	N	Heart Murmur
Y	N	Any operations	Y	N	Hemophilia
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Cancer	Y	N	Hepatitis
Y	N	Congenital Heart Defect	Y	N	Kidney/Liver Problems
Y	N	Convulsion/Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Tuberculosis			

Please discuss any of the yes responses above: _____

Do you now or have you had any of the following habits?

Y N Clenching/Grinding Teeth Y N Speech Problems

Y N Mouth breathing Y N Thumb/Finger Sucking

Y N Tongue Thrust

I understand that 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 dental or medical condition.

I authorize the dental staff to perform the necessary dental services that I may need.

Signature

Date