

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: ____ - ____ - ____

School: _____ Hobbies: _____

Whom may we thank for referring you? _____

List brothers, sisters, and ages: _____

Have we treated any of these children? _____

General Dentist: _____ Last visit: _____

FATHER'S INFORMATION:

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

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

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

Orthodontic coverage: Yes _____ No _____

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

MOTHER'S INFORMATION

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

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

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

Orthodontic coverage: Yes _____ No _____

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

PERSON RESPONSIBLE FOR ACCOUNT: (If different from above)

Name: _____ Relationship to patient: _____

Billing Address: _____

Home Telephone Number: ____ - ____ - ____ Work: ____ - ____ - ____

(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:

- Has your child ever been evaluated or had orthodontics before? _____
- Have there been any injuries to the face, mouth, teeth, or chin? _____
- Have adenoids or tonsils been removed? _____
- Has your child been informed of any missing or extra permanent teeth? _____
- Has your child had any pain or tenderness in his/her jaw bone joint? _____
- Has your child ever been told by physician to take antibiotics before dental procedures? _____

Child's physician: _____ Telephone # _____ - _____ - _____

Approximate date of last visit: _____

Is your child currently under the care of a physician? Yes No

Please describe your child's current physical health: Good Fair Poor

Please list any drugs that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

Has your child 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: _____

Does your child have 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 child's dental or medical condition.

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

Signature of parent or guardian

Date