ORTHODONTIC ASSOCIATES OF MERCER ISLAND
mercerislandsmiles.com

Kara J. McCulloch **DMD • MSD** R. William McNeill **DDS • MS**

PATIENT INFORMATION

First: _____ Middle Initial: _____ Last: _____ Nickname: _____

Birth Date: _____ Gender: _____ Email: _____

Phone: _____ Cell/Alternate Phone: _____

Address: _____ City/State: _____ Zip: _____

Preferred method of written communication (please circle one): Email Mail

List friends or relatives in the practice: _____

How did you find out about our office? _____

List any sports, hobbies, or musical instruments played: _____

FINANCIAL PARTY INFORMATION (IF INFORMATION IS DIFFERENT THAN PATIENT)

First: _____ Last: _____

Phone: _____ Cell/Alternate Phone: _____

Email: _____

Address: _____ City/State: _____ Zip: _____

Relationship to Patient: _____ Occupation: _____

ORTHODONTIC INSURANCE INFORMATION (PLEASE LIST DENTAL POLICIES WITH ORTHODONTIC COVERAGE)

Insurance Co. Name: _____ Address: _____ Phone: _____

Subscriber's Name: _____ Subscriber's #/SS: _____ Birth Date: _____

Subscriber's Employer: _____ Group #: _____ Phone: _____

DENTAL HISTORY

Patient's Dentist: _____ Phone: _____ Last Cleaning: _____

Please describe your orthodontic problem: _____

Has the patient had any previous orthodontic treatment? With whom? _____

What concerns you most about the thought of orthodontic treatment? _____

Please select YES if the patient has had any of the conditions listed below either currently or in the past.

Speech problems/therapy?	☐ YES ☐ NO	Floss teeth daily?	☐ YES ☐ NO
Grind or clench teeth?	☐ YES ☐ NO	Fluoride treatments?	☐ YES ☐ NO
Oral habits (thumb/finger sucking, lip/nail biting)?	☐ YES ☐ NO	Mouth breathing?	☐ YES ☐ NO
Injury to face, jaw, teeth, or mouth?	☐ YES ☐ NO	Snores during sleep?	☐ YES ☐ NO
Discomfort from teeth or gums?	☐ YES ☐ NO	Any missing or extra permanent teeth?	☐ YES ☐ NO
Pain, tenderness, or noise in either jaw?	☐ YES ☐ NO	Apprehensive about dental care?	☐ YES ☐ NO
Frequent sore throats?	☐ YES ☐ NO	Frequently chews gum?	☐ YES ☐ NO
Requires premedication?	☐ YES ☐ NO	Ringing in the ears?	☐ YES ☐ NO
Brush teeth daily?	☐ YES ☐ NO		

If you answered YES to any of the questions above, please explain: _____

MEDICAL HISTORY

Patient's Physician: _____ Address: _____

Phone: _____ Is patient in good health? □ YES □ NO Date of last physical: _____

Please list any medications currently being taken by patient: _____

Have you taken any Bisphosphonates? □ YES □ NO If YES, when? _____

Please list any drug allergies/sensitivities patient may have: _____

Please select YES if the patient has had any of the conditions listed below either currently or in the past.

Rheumatic Fever	□ YES □ NO	Cancer	□ YES □ NO
Tuberculosis/Lung Disease	□ YES □ NO	Family History of Cancer	□ YES □ NO
Pneumonia	□ YES □ NO	Received Radiation Therapy	□ YES □ NO
Liver Disease	□ YES □ NO	Growth Problems	□ YES □ NO
Kidney Disease	□ YES □ NO	Endocrine Problems	□ YES □ NO
Heart Attack/Stroke	□ YES □ NO	Hormone Therapy	□ YES □ NO
Heart Disease	□ YES □ NO	Latex/Metal Allergy	□ YES □ NO
Congenital Heart Defect	□ YES □ NO	Nervous Disorders	□ YES □ NO
Heart Murmur	□ YES □ NO	Bone Disorders/Bone Loss	□ YES □ NO
Hemophilia	□ YES □ NO	Diabetes	□ YES □ NO
Hypertension/High Blood Pressure	□ YES □ NO	Seizures/Epilepsy	□ YES □ NO
Prolonged Bleeding/Transfusion	□ YES □ NO	Handicaps/Disabilities	□ YES □ NO
Anemia	□ YES □ NO	Asthma	□ YES □ NO
HIV/AIDS	□ YES □ NO	Arthritis	□ YES □ NO
Hepatitis	□ YES □ NO	Treated for Emotional Problems	□ YES □ NO
Tonsils/Adenoids Removed	□ YES □ NO	Ever Been Hospitalized	□ YES □ NO

If you answered YES to any of the questions above, please explain: _____

_____

_____

Signature: _____ Date: _____

If the patient is under the age of 18, please answer the following questions:

Height: _____ Weight: _____ School: _____ Grade: _____

If patient is a girl, has menstruation began? □ YES □ NO If so, when? _____

If patient is a boy, has their voice changed? □ YES □ NO

Has the patient grown in the past year or has their shoe size changed recently? □ YES □ NO

Is patient interested in orthodontic treatment? □ YES □ NO

Has either biological parent ever had orthodontic treatment? □ YES □ NO

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Married □ Single □ Separated □ Divorced □ If separated or divorced, which parent does child live with? _____

Please list the name and birth date of any siblings: _____

_____