McDonald Orthodontics
1855 West Nob Hill Street, Suite 300, Salem, OR 97302 -- 164 Chemawa Road N, Keizer, OR 97303 -- (503) 585-5400 -- www.salembraces.com

A B C

Confidential Patient Information

Patient Name: _____ (Last / First / Middle)

Birthdate: _____

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

Confidential Responsible Party Information

Name: _____ (Last / First / Middle) Marital Status: _____

Residence: _____ (Street / City / State / Zip)

Mailing Address: _____ (Street / City / State / Zip) Email: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ (Last / First / Middle) Relationship to Patient: _____

Spouse Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse Social Security #: _____ Spouse Birthdate: _____ Spouse Cell Phone: _____

Insurance Information

***Complete <u>or</u> provide your insurance card to copy for your file.**
Policy Holder's Name: _____
Birthdate: _____ SSN: _____
Insurance Co. Name: _____
Group #: _____ Union Local #: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Policy Holder's Employer: _____

Do you have dual coverage? ☐ No ☐ Yes If yes:
Policy Holder's Name: _____
Birthdate: _____ SSN: _____
Insurance Co. Name: _____
Group #: _____ Union Local #: _____
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 authorize this office to release any information necessary to submit and expedite insurance claims. I understand that I am responsible for all costs of orthodontic treatment, regardless of insurance coverage. I understand that where appropriate, credit bureau reports may be obtained. I acknowledge that a copy of McDonald Orthodontics' Notice of Privacy Practices will be provided upon my request.

Signature (Parent's signature if minor): _____ Date: _____

<u>Please Continue on Back Side</u>

Patient Medical History

1. Are you in good health?---------- ☐ Yes ☐ No
2. Are you under the care of a physician? ---------- ☐ Yes ☐ No

   If yes, what condition: _____

3. Are you currently taking any medications? (Including over-the-counter and herbal) ---------- ☐ Yes ☐ No

   If yes, please list medications: _____

   Do you take NSAIDs regularly? _____ ☐ Yes ☐ No

4. Do you have or have you had any of the following problems or diseases? (check box if yes)
   - ☐ Heart Murmur - If yes, do you take medication prior to dental appointments? ☐ Yes ☐ No
   - ☐ Heart Problem
   - ☐ Hepatitis, Jaundice or Liver Disease
   - ☐ Asthma or Hay Fever
   - ☐ Diabetes
   - ☐ Aids
   - ☐ Other _____

5. Are you allergic to any drugs/medications (such as penicillin, codeine, aspirin) or have a latex allergy? - ☐ Yes ☐ No

   If yes, what are you allergic to? _____

6. Do you have any disease, condition or other problems not listed that you think we should know about? - ☐ Yes ☐ No

   If yes, describe: _____

Patient Dental History

1. Do you have any pending dental work?---------- ☐ Yes ☐ No

   If yes, what? _____

2. When was your last dental check-up? _____
3. When was your last dental cleaning? _____
4. Have you ever had any abnormal bleeding associated with previous extractions, surgery or trauma? ----- ☐ Yes ☐ No
5. Do your gums bleed?---------- ☐ Yes ☐ No
6. Are you aware of grinding or clenching your teeth? ---------- ☐ Yes ☐ No
7. Have there been any injuries to face, mouth or teeth? ---------- ☐ Yes ☐ No
8. Do you have any speech problems? ---------- ☐ Yes ☐ No
9. Have you ever been told of any missing or extra permanent teeth? ---------- ☐ Yes ☐ No
10. Do you experience pain or clicking in your jaw, ear or facial muscles upon opening your mouth?-------- ☐ Yes ☐ No
    Headaches?---------- ☐ Yes ☐ No

    Please describe: _____

11. Do you have or have you ever had any of the following habits?
    - ☐ Thumb Sucking---------☐ Current ☐ Previously
    - ☐ Nail Biting----------☐ Current ☐ Previously
    - ☐ Tongue Sucking --------☐ Current ☐ Previously
    - ☐ Mouth Breathing--------☐ Current ☐ Previously
    - ☐ Tongue Thrusting-------☐ Current ☐ Previously
    - ☐ Lip Biting----------☐ Current ☐ Previously
    - ☐ Tongue Biting----------☐ Current ☐ Previously
    - ☐ Abnormal Breathing ---☐ Current ☐ Previously

12. Why are you seeking an orthodontic consultation? _____

_____

It is your obligation to inform us of any health changes.