Charles B. McDermott DDS, MS ORTHODONTICS

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ___/___/___

Name: _____
LAST FIRST MI MR., MRS., MS., DR.

I prefer to be called: _____ ❑ Male ❑ Female

Home Address _____
APT./CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm #: (____) _____ Cell #: _____

Wk #: (____) _____ Ext.: _____

Employer: _____

Other family members seen by us: _____

General Dentist: _____ Last Visit Date: _____

2 Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (____) _____ Ext.: ____ SS #: _____

Birthdate: ___/___/___

3

How did you hear about our office?

❑ Dentist ❑ Friend ❑ Yellow Pages ❑ Newspaper

_____

_____

4

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

_____

_____

_____

_____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group #: (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: ___/___/___ SS#: _____

Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group #: (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: ___/___/___ SS#: _____

Policy Owner's Employer: _____

6 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin
Y N Any Metals/Plastics	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

Please list any other drugs/materials that you are allergic to: _____

_____

_____

_____

continued on back

6 Medical History continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

_____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems

Y N	Abnormal Bleeding/Hemophilia	Y N	Herpes / Fever Blisters
Y N	AIDS	Y N	High Blood Pressure
Y N	Alcohol / Drug Abuse	Y N	HIV
Y N	Anemia	Y N	Hospitalized for Any Reason
Y N	Arthritis	Y N	Kidney Problems
Y N	Artificial Bones / Joints / Valves	Y N	Liver Disease
Y N	Asthma	Y N	Low Blood Pressure
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer / Chemotherapy	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Radiation Treatment
Y N	Difficulty Breathing	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease / Traits
Y N	Frequent Headaches	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart Attack / Surgery	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers
Y N	Hepatitis	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

7 Dental History

Have you ever had or been evaluated for orthodontic treatment? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No Gums ever bleed? ❑ Yes ❑ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems: _____

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes, please circle: While awake? While asleep?

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No

Further notes:

_____

_____

_____

_____

8

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Doctor's Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N

If Yes, please explain: _____

Has there been any change in your health status since your last visit? Y N

If Yes, please explain: _____

_____

Patient Signature Date

_____

Dentist Signature Date

_____

Patient Signature Date

_____

Dentist Signature Date