MAGINNIS ORTHODONTICS

NEW PATIENT INFORMATION

Sex ☐ Male ☐ Female

Date____ __________ Date of Birth____________________Age_____________

Patient's Name____ School_________________________Grade_____________

Name Patient prefers to be called________________________________ Physician____

Email Address____

Patient's Dentist____

How did you hear about our office?____

RESPONSIBLE PARTY INFORMATION

Please Check ☐ Self ☐ Father ☐ Step-Father ☐ Mother ☐ Step-Mother ☐ Grandparent

Name ____

Address ____

City, State, Zip ____

Home Phone ____

Work Phone/Cell Phone ____

Email Address ____

Occupation ____

Parent's Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

INSURANCE INFORMATION

Insurance Company ____ Insurance Phone # ____

Claims mailing address____City_________________State_______Zip_________________________________

Subscriber Name_____________________________________Subscriber ID_____________________Group______________________________________

Subscriber Date of Birth__________________Subscriber Social Security #__________________Employer____

MEDICAL HISTORY

Is the patient in good health? ☐ Yes ☐ No Explain____

Any major or unusual illnesses? ☐ Yes ☐ No Explain____

Currently under physician's care? ☐ Yes ☐ No Explain____

Currently taking medication? ☐ Yes ☐ No Explain____

Any allergies or drug sensitivity? ☐ Yes ☐ No Explain____

Any latex allergy? ☐ Yes ☐ No Explain____

Do you need prophylactic antibiotic coverage prior to dental procedures? ☐ Yes ☐ No For what reason?____

Have you ever taken Bisphosphonate medications (examples: Fosamax, Boniva, Actonel, Zometa)? ☐ Yes ☐ No

For How Long?____

PLEASE CIRCLE THE FOLLOWING AS THEY APPLY

ADHD/ADD	Emotional Problems	Hearing Disorder	Kidney Disease
Allergies or Asthma	Epilepsy	Heart Trouble	Liver Disease
Autism	Endocrine Problems	Hepatitis	Nervous Disorder
Bleeding Problems	Glaucoma	HIV/AIDS	Speech Disorder
Diabetes	Head or Facial Injury	High Blood Pressure	Other

Notes regarding above conditions:____________________________

(For Patients under 18)

Has the Patient reached puberty? ☐ Yes ☐ No

Has there been a drastic change in shoe size recently? ☐ Yes ☐ No

Females: Has the patient started menstruation? ☐ Yes ☐ No If yes, what age?____________________

Males: Has the patient's voice changed? ☐ Yes ☐ No If yes, what age?____________________

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No If yes, explain:____________________

Is there presently a thumb sucking or finger sucking habit? ☐ Yes ☐ No

Has the patient consulted an orthodontist previously? ☐ Yes ☐ No If yes, what office?____________________

Has the patient had orthodontic treatment previously? ☐ Yes ☐ No If so, by whom and when?____________________

What part of your child's orthodontic problem concerns you the most?____________________________

I have read and understand the above questions. I will not hold my orthodontist or staff members responsible for errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice. I hereby consent to orthodontic examination provided by Dr. Maginnis and authorize Dr. Maginnis to obtain or provide medical/dental history or other information related to orthodontic treatment from or to other healthcare providers.

Signature____________________________ Date____________________