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 Martial 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 medicine?	☐ 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	Speed 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 alter to his history record or medical/dental history or other information related to orthodontic treatment form or to other healthcare providers.

Signature_____ Date_____