245 South Main Street, Pennington, NJ 08534 ▯ 609-730-1414
www.Bracez4You.com ▯ FAX: 609-730-1456 ▯ NJ Specialty Permit #3919
Diplomate, American Board of Orthodontics

Adult Patient Information

Name: Ms. / Mrs. / Mr. / Dr. ______________________________ Prefer to be called:________________ Sex:______
First Last

Address:________________________________City:___________________________State:______Zip:_________

Primary Phone: ______________________ home/cell # E-Mail:____

Secondary Phone: ____________________ home/cell # Birth Date:____________________ Age:________________

Employer:____ Bus. Phone:_____________________

Marital Status (please circle): Single Married Divorced Separated Widow(er)

Who will be responsible for payment of this account?___________________________ Is there dental insurance?______

If you have Dental Insurance, please complete:

Insured/Subscriber Name:_______________________________________ Employer:________________________

ID # or Soc. Security # of Insured:_________________________________ Birthdate of Insured________________

Insurance Co.____Group or Plan # ________________________

Whom may we thank for referring you?____

Please describe your orthodontic concerns:____

____

If we could wave a magic wand and change one thing about your smile what would it be?_____________________________

Dental History

General Dentist:_____________________ Address:___________________________ Phone #:_______________________

(Circle appropriate information)
Frequency of dental checkups: Twice a year / Once a year / Only if a problem arises / Never / Date of last cleaning**:**_______
Is there any unfinished care to be completed with your dentist? No Yes Explain:______________________________
Do you need to be pre-medicated for dental visits? No Yes Explain:______________________________
Have teeth (either baby or permanent) been removed? No Yes Explain:______________________________
Have you ever had any facial or dental injuries? No Yes Explain:______________________________
Have you ever had periodontal (gum) disease? No Yes Explain:______________________________
Have you ever consulted an orthodontist previously? No Yes Explain:______________________________
Do you desire orthodontic treatment? No Yes Explain:______________________________

Please **CIRCLE** if there is a history of:
Clenching Teeth Jaw joint clicking Jaw joint soreness Jaw joint popping Grinding teeth Ringing in the ears
Headaches (more than normal) Muscular soreness around head & neck Bleaching your teeth (date) _____________
Speech Problems (if so, which sounds)___________________ Mouth breathing while awake and/or asleep

Is there any other information that may be helpful?____

____

Please Turn Over

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing for your dental care. All information will be kept completely confidential.

Medical History

Physician's Name:____Last Visit:______________________

Address: ____ Phone: _______________________

Question			
Have you ever experienced any health problems?	No	Yes	Explain:_________________________________
History of snoring and/or sleep apnea?	No	Yes	Explain:_________________________________
Any major change in your health recently?	No	Yes	Explain:_________________________________
Are you currently under physician's care?	No	Yes	Explain:_________________________________
Are you currently taking medications?	No	Yes	Explain:_________________________________
Are you allergic to any medications?	No	Yes	Explain:_________________________________
Have you received a blood transfusion?	No	Yes	Explain:_________________________________
Have your tonsils or adenoids been removed?	No	Yes	Explain:_________________________________
Have you been in a risk group for AIDS?	No	Yes	Explain:_________________________________
Are you pregnant?	No	Yes	# months_________________________________
Do you smoke?	No	Yes	How much:________________________________
Have you **ever** taken Bisphosphonate drugs?	No	Yes	When? _________Why?____________________

(Examples of Bisphosphonates = Fosamax, Didronel, Boniva)

Please circle if you have had any of the following conditions:

Condition			Condition			Condition		
Heart Murmur	No	Yes	Hepatitis	No	Yes	Emotional Problems	No	Yes
Heart Surgery	No	Yes	Diabetes	No	Yes	Frequent Headaches	No	Yes
Rheumatic Fever	No	Yes	Kidney Disease	No	Yes	Nervous/Anxious	No	Yes
Endocrine Disorders	No	Yes	Liver Disease	No	Yes	Cancer	No	Yes
Prolonged Bleeding	No	Yes	Tuberculosis	No	Yes	Bone Disorders	No	Yes
Anemia	No	Yes	Bronchitis	No	Yes	Growth Disorders	No	Yes
Blood Disease	No	Yes	Asthma	No	Yes	Mouth Breather	No	Yes
Developmental Disorder	No	Yes	Epilepsy	No	Yes	Herpes (Fever Blisters)	No	Yes
Hives/Rash	No	Yes	Fainting	No	Yes	Latex Allergy	No	Yes

Any other health problems or special concerns:____

____

Comments:____

INSURANCE: To avoid misunderstandings regarding dental insurance, all professional services rendered are charged directly to the patient and the patient, parent and/or guardian are responsible for payment of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company. In order to do so, please sign below authorizing Dr. McDonough's office to submit any insurance claims as well as to provide each respective insurance company, claim administrator and consulting health care professional information concerning health care, advice, treatment, or supplies provided. This form also authorizes release of any information relating to a claim submitted on your behalf. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one of more credit reporting services.

I have read and understand the above questions. If there are any changes later to this history record or medical/dental status I will inform this practice.

*Patient's Signature:*____*Date:*____________________

For Future Use

Changes since last history:____

____

Signature:____Date: _____________