We make great smiles happen!
MARK McDONOUGH D M D
ORTHODONTIST

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Diplomate, American Board of Orthodontics

Child Patient Information

Child's Name:_____ Prefer to be called:_____ Sex:_____
First Last

Address: _____ City:_____ State:_____ Zip:_____

Primary number: _____home/cell # Parent E-Mail:_____ Birth date: _____ Age:____

Secondary number: _____ home/cell #

School: _____ Grade: _____ Sports/Hobbies: _____

Father's Name: _____ Employer: _____ Work / Cell #: _____
First Last (circle)

Mother's Name: _____ Employer: _____ Work / Cell #: _____
First Last (circle)

Parent's Marital Status: Single Married Divorced Separated Widow(er)

Number of children in family:_____ Birthdate/Name: (/ / :) (/ / :) (/ / :)

Patient's Height: _____ Mother's Height: _____ Father's Height: _____

Who will be responsible for the payment of this account?_____

Do you have dental insurance with ortho. coverage? Y / N Insured/Subscriber _____ Ins. Co._____

Group #: _____ Soc. Sec / ID# of Insured: _____ Birth date of Insured: _____

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 child's 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 child's dentist?	No	Yes	Explain: _____
Does your child need to be pre-medicated for dental visits?	No	Yes	Explain: _____
Have teeth (either baby or permanent) been removed?	No	Yes	Explain: _____
Has your child had any facial or dental injuries?	No	Yes	Explain: _____
Is there any history of thumb or finger sucking?	No	Yes	Explain: _____
Does your child play a musical instrument?	No	Yes	Explain: _____
Has your child consulted an orthodontist previously?	No	Yes	Explain: _____
Does the patient 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 Whitening of Teeth (Date:_____)
Speech problems (if so, which sounds) _____ Mouth breathing while: Awake 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

Child's Physician: _____ Last Visit: _____

Address: _____ Phone: _____

Is child in good health?	No	Yes	Explain_____
History of snoring	No	Yes	How often?_____
Is your child a good sleeper?	No	Yes	# of hours sleep/night_____
Serious illness or hospitalization?	No	Yes	Explain:_____
Child taking any drugs or medication?	No	Yes	Explain:_____
Is there an allergy to penicillin or other drugs?	No	Yes	Explain:_____
Is there an allergy to Latex?	No	Yes	Explain:_____
Rheumatic fever, heart disease, murmur?	No	Yes	Explain:_____
Tonsils and/or adenoids removed?	No	Yes	Explain:_____
Any learning disorders or emotional problems?	No	Yes	Explain:_____
Is the patient sensitive, self-conscious?	No	Yes	Explain:_____
Behavioral Disorder (ADD/ADHD/Autism/OCD)?	No	Yes	Explain:_____
Birth defects or hereditary problems?	No	Yes	Explain:_____
Bone fractures or major accidents?	No	Yes	Explain:_____
Fainting spells, seizures, neurological problems?	No	Yes	Explain:_____
Does the patient smoke?	No	Yes	How much: _____
Under treatment of another professional?	No	Yes	Explain:_____
If female, has menstruation begun?	No	Yes	At what age?_____
If yes, could the patient be pregnant?	No	Yes	# of months: _____
Has your child ever taken Bisphosphonate drugs? (Examples of Bisphosphonates = Fosamax, Didronel, Boniva)	No	Yes	When?_____Why?_____

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.

*Authorized Guardian's Name:*_____

*Authorized Guardian's Signature:*_____*Date:*_____

For Future Use

Changes since last history:_____

_____

Signature:_____Date: _____