McGeth ORTHODONTICS
4003 Financial Parkway • Rogers, AR 72758
479-621-8229

Date_____

(Black/Blue Ink ONLY)

Health History

Patient Name_____ (Last / First / Middle)

Address_____ (Street / City / State / Zip)

Home Phone_____ Birthdate_____ Email Address_____

If patient is a minor, give parent's or guardian's name_____School_____

How did you hear about our office?_____

Confidential Responsible Party Information

Name_____ (Last / First / Middle) Marital Status_____

Residence_____ (Street / City / State / Zip)

Mailing Address_____ (Street / City / State / Zip)

How long at this address_____ Home Phone_____ Work Phone_____ Cell Phone_____

Previous Address (if less than 3 yrs.)_____ (Street / City / State / Zip)

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ (Last / First / Middle) Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____ Cell Phone_____

Insurance Information

Policy Holder's Name_____ ID #/Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ❒ Yes ❒ If yes:

Policy Holder's Name_____ ID #/Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

MEDICAL INFORMATION

	YES/NO
Any Heart Disease:	
Any Respiratory Disease:	
Any Blood Disease:	
Any Liver Disease:	
Any Thyroid Disease:	
Any Kidney Disease:	
H.I.V. Positive:	
Any Venereal Disease:	
Any Intestinal Disease:	
Any Bone Disease:	
Any Nervous/Emotional Problems:	
Any High or Low Blood Pressure:	
Any Endocrine Problems:	
Any Problems with Wounds Healing:	
Any Tumors or Cancer:	

	YES/NO
Heart Murmur:	
Mononucleosis:	
Hepatitis:	
Polio:	
Diabetes:	
Anemia:	
Hemophilia:	
Emphysema:	
Epilepsy:	
Psychiatric or Psychological counseling:	
Spina Bifida:	
Urogenital Anomalies:	

	YES/NO
Rheumatic/Yellow/Scarlet Fever:	
Acquired Immune Deficiency Syndrome:	
Is Patient Under Medical Care:	
Rheumatism or Arthritis:	
A History of Fainting or Dizziness:	
Does the Patient have a Drug Addiction:	
Is the Patient Pregnant at this Time:	
Measles/Mumps/Chicken Pox:	
Does the Patient Smoke:	
Is the Patient in Good Health:	
Is Height & Weight Normal for Age:	
Has the Patient ever had Fever Blisters:	
Artificial Valves or Joints:	
Has the Patient Reached Puberty:	
If under 16 and female, what was the age of onset for menstrual cycles?	

	YES/NO
Asthma or Hay Fever:	
Tuberculosis:	
Any Broken Bones:	
Prolonged Bleeding:	
Yellow Jaundice:	
Radiation Therapy:	
Chemical Therapy:	
Blood Transfusions:	
Is the Patient Allergic to any Medications:	

If yes, list Medications:_____

_____

	YES/NO
Is the Patient taking any Medications:	

If yes, list Medications:_____

_____

Are you aware of any other disease, condition, or problem not listed above that we should know about: If yes, What: _____

_____

DENTAL HISTORY

	YES/NO
Has the Patient Seen a General Dentist in the Last Year:	
Any Pain, clicking or discomfort In or Near the Ears:	
Are You Aware of Any "Gum" Problems:	
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:	
If yes, how_____	
Has a Physician or Dentist Advised Antibiotic Before a Dental Exam? If yes, what:_____	
Have the Patient's Tonsils or Adenoids Been Removed:	
Do you Feel the Patient can Benefit from Orthodontic Treatment:	
Is the Patient Happy with Their "SMILE":	
Does the Patient Want to Improve Their "SMILE" and "BITE":	
Would the Patient Mind Wearing "BRACES":	

Does the Patient Have or Ever Had Any of the Following Habits:

	YES/NO		YES/NO
Cheek, Tongue or Lip Chewing		Clenching Teeth:	
Thumb Sucking:		Tongue Thrusting:	
Mouth Breathing:		Grind Teeth:	
Fingernail Biting:		Speech Problems:	

Date of last Dental Cleaning:_____

Has the Patient Been Examined by an Orthodontist Before:

If Yes, When:_____

Have Other Members of the Family had Orthodontic Treatment:

If Yes, Were You Happy With the Results:

If No, Why:_____

What is your chief concern/what would you like orthodontic treatment to accomplish:_____

OTHER INFORMATION

Dentist Name:_____
(First/Last Name Please)

Physician Name:_____
(First/Last Name Please)

Sports or Hobbies:_____
(First/Last Name Please) (Mo/Day/Yr)

Other Children:_____ Birthday:_____

Other Children:_____ Birthday:_____

Other Children:_____ Birthday:_____

Other Children:_____ Birthday:_____

FOR OFFICE USE ONLY

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