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Patient Information

Patient Name _____ Age _____
Preferred Name _____ Male Female Birthdate _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Cell Phone () _____
School (If under 18) _____ Grade _____
Hobbies _____
Whom may we thank for referring you? _____
Email _____
Whom will be bringing you to your first appointment? _____
List of names whom we may speak with in regards to your treatment? _____

Whom should we contact for appointment reminders via text in the future? _____
 Yes No Have any other family members been treated by Dr. McManus? If "yes," who? _____

Responsible Party Information

Living with: Mother Father Both Other
Marital Status: Single Married Widowed Divorced Separated Domestic Partner
Fathers Name _____ Mothers Name _____
Step Mother's Name _____ Step Father's Name _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Birthdate _____ Birthdate _____
Home Phone () _____ Home Phone () _____
Cell Phone () _____ Cell Phone () _____
Employer _____ Employer _____
Occupation _____ Occupation _____
Work Phone () _____ Work Phone () _____

Orthodontic Insurance Information

Primary

Policy Holder's Name _____ Birthdate _____
Relationship to patient _____ Social Security # _____
Employer _____ Insurance Company _____
Insurance Company Address _____

Secondary

Policy Holder's Name _____ Birthdate _____
Relationship to patient _____ Social Security # _____
Employer _____ Insurance Company _____
Insurance Company Address _____

Medical and Dental History

Medical

Physician _____ Phone () _____

List any medications currently taken: _____

- Yes No Is the patient under the care of a physician? If "yes," for what condition? _____
- Yes No Is the patient pregnant?
- Yes No Any changes in general health within the last year? _____
- Yes No Any sensitivities or allergies? If "yes," please list: _____
- Yes No Any bisphosphonates or bone density medications ever been taken? (i.e., Boniva or Fosomax)
- Yes No Does the patient smoke, vape, or use any tobacco products? If "yes," please list: _____
- Yes No Have tonsils or adenoids been removed?
- Yes No Are frequent headaches present?
- Yes No Has a physician or dentist recommended that an antibiotic be taken before dental treatment? _____

Has the patient been treated for any of the following in the past year? (circle below any that apply)

Arthritis Asthma Blood Disorder Cancer Connective Tissue Disorder Epilepsy Heart Condition Kidney Disorder
Nervous Disorder Tuberculosis

Dental

Primary Dentist _____ Phone () _____

Date of last dental visit? _____

- Yes No Has the patient ever seen an orthodontist? If "yes," when? _____
- Yes No Any missing or extra teeth?
- Yes No Any injuries to the face, mouth, or chin?
- Yes No Any primary (baby) or permanent teeth removed by the dentist?
- Yes No Pain/tenderness in the jaw joint (TMJ/TMD)?
- Yes No A musical instrument with a mouthpiece? If "yes" which one? _____
- Yes No Are there other dental issues not listed that you would like to discuss or have treated?

If "yes," please explain _____

Has the patient had any of the following habits or dental conditions in the past year? (circle below any that apply)

Grinding Teeth Finger/Thumb Sucking Tongue Thrusting Mouth Breathing Speech Problems Chewing/Eating Problems
Gingivitis/Periodontal Disease

Your "Smile" Questionnaire

What changes would you like to see? _____

Are you concerned with any of the following? (please check all that apply)

- Yes No Teeth that are crooked or crowded?
- Yes No Spaces between teeth?
- Yes No Front teeth "sticking out" too much?
- Yes No Too much or too little gum tissue showing when smiling?
- Yes No An overbite or underbite?
- Yes No Profile or facial appearance

OFFICE USE ONLY
CLASS
OB:
OJ:
ALDU:
ALDL:

I understand that the information that I have provided is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in the medical status. I authorize McManus Orthodontics to release necessary information including diagnosis and diagnostic records to third party payers or practitioners.

I consent to examination by the doctor to determine details of malocclusion.

Signature

Signature (If under 18, have responsible adult person sign) _____ Date _____



Privacy Consent

This form is optional under the new patient regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign, and date this form.

Your protected health and personal information (i.e., individually identifiable information such as; names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation, and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restriction on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke the Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Name _____

Parent's Name (if patient is under 18) _____

Signature (If under 18, have responsible adult person sign) _____ Date _____