Meehan ORTHODONTICS

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The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.
Please fill out these forms completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____
Apt./Condo #

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: _____ Pager/Other #: _____

Work #: _____ Ext.: _____ DL#: _____

Employer: _____

Employer's Address: _____

How long there: _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we *thank* for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last visit date: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work #: _____ Ext.: _____ SS#: _____

Birthdate: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Work #: _____ Ext.: _____ Home #: _____

Billing Address: _____
Zip

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

# of years employed: _____

ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (plan, local or policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ SS#: _____

Insured's Employer: _____

SECONDARY

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (plan, local or policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____

Work #: _____ Home #: _____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Form Continued On Back ☞

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meehanorthodontics.com

MEDICAL HISTORY CONT'D.

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs?

❑ Yes ❑ No

Please list each one: _____

Have you ever had any of the following diseases or medical problems?

Y	N	Heart Attack/Stroke	Y	N	Psychiatric problems
Y	N	Cancer/Chemotherapy	Y	N	Epilepsy/Seizures/Fainting
Y	N	Heart Murmur	Y	N	Diabetes
Y	N	Rheumatic Fever	Y	N	Drug/Alcohol Abuse
Y	N	HIV+/AIDS	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery/Pacemaker	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Shingles	Y	N	Ulcers/Colitis
Y	N	Mitral Valve Prolapse	Y	N	Congenital Heart Defect
Y	N	Kidney problems	Y	N	Anemia/Radiation Treatment
Y	N	Artificial Bones/Joints	Y	N	Asthma/Arthritis
Y	N	Artificial Valves	Y	N	Difficulty Breathing
Y	N	Sinus problems	Y	N	Hospitalized for any reason
Y	N	High/Low Blood Pressure	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Blood Transfusion
Y	N	Severe/Frequent Headaches	Y	N	Emphysema/Glaucoma
Y	N	Wears Contact Lenses	Y	N	Glaucoma, eye problems
Y	N	Thyroid Disease	Y	N	Chronic Cough

Please list any medical condition(s) that you have ever had:

_____

Are you allergic to any of the following items?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Codeine
Y	N	Erythromycin	Y	N	Any metal/plastic	Y	N	Other

Please list any other drugs that you are allergic to: _____

_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Have you ever had or been evaluated for orthodontic treatment?

❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Good ❑ Fair ❑ Poor

Have you ever had an injury to your: Mouth Teeth Chin

Please Circle

Do you have any speech problems? _____

_____

Do you generally breath through your mouth?

❑ Yes ❑ No Awake? ❑ Yes ❑ No Asleep?

Do you have any missing or extra permanent teeth?

❑ Yes ❑ No

I understand that the .information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____

Signature Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein, Initials _____ Date _____

Doctor's Comments: _____

_____