Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!

(615) 851-1222 · MCKOENORTHO.COM
2020 CALDWELL DR, GOODLETSVILLE, TN 37072

Patient Information

NAME ______ PREFERRED NAME ______ ☐ M ☐ F

BIRTHDATE ______ AGE ______ GRADE ______ SCHOOL ATTENDS ______

HOME PHONE ______ CELL PHONE ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______

NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO TODAY'S APPOINTMENT ______

WHO HAS LEGAL CUSTODY OF PATIENT? ______

NAME OF SIBLINGS & AGES ______

HAVE WE TREATED ANY FAMILY MEMBERS? IF YES, WHO? ______

WHOM MAY WE THANK FOR REFERRING YOU? ______

Responsible Party

☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

MOTHER'S NAME ______

☐ PARENT ☐ GUARDIAN ☐ STEPMOTHER

DATE OF BIRTH ______ SSN ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

HOW LONG AT THIS ADDRESS? ______

CELL PHONE ______

WORK PHONE ______

EMPLOYER ______ YEARS EMPLOYED ______

OCCUPATION ______

EMAIL ______

FATHER'S NAME ______

☐ PARENT ☐ GUARDIAN ☐ STEPFATHER

DATE OF BIRTH ______ SSN ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

HOW LONG AT THIS ADDRESS? ______

CELL PHONE ______

WORK PHONE ______

EMPLOYER ______ YEARS EMPLOYED ______

OCCUPATION ______

EMAIL ______

Primary Insurance Information

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY ______ INSURANCE PHONE NUMBER ______

EMPLOYER/GROUP NAME ______ GROUP NUMBER ______

SUBSCRIBER/EMPLOYEE ______ SUBSCRIBER ID/SSN ______

DATE OF BIRTH ______ RELATIONSHIP TO PATIENT ______

Secondary Insurance Information

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY ______ INSURANCE PHONE NUMBER ______

EMPLOYER/GROUP NAME ______ GROUP NUMBER ______

SUBSCRIBER/EMPLOYEE ______ SUBSCRIBER ID/SSN ______

DATE OF BIRTH ______ RELATIONSHIP TO PATIENT ______

Emergency Contact Information (OTHER THAN RESPONSIBLE PARTY)

NAME ______ RELATIONSHIP TO PATIENT ______

HOME PHONE ______ CELL PHONE ______

Please take a moment to complete the reverse side of this form.

PLEASE READ: We are passionate about our mission to give everyone a great smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc. ____________

____

Medical History

PHYSICIAN ____________ PHONE ____________ DATE OF LAST EXAM ____________

	Y	N
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS?	☐	☐
3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING?		
4. DO YOU USE TOBACCO?	☐	☐
5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS?	☐	☐
IF YES, WHAT?		
6. FEMALES ONLY:		
A. HAS MENSTRUATION BEGUN? IF YES, DATE: ________	☐	☐
B. ARE YOU PREGNANT, OR THINK YOU MAY BE?	☐	☐
7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? IF YES, SPECIFY ____________	☐	☐
8. HAS THE PATIENT REACHED PUBERTY?	☐	☐

9. PLEASE CHECK ALL THAT APPLY:

HAY FEVER/ALLERGIES	☐	LEUKEMIA	☐
COLD SORES	☐	KIDNEY/LIVER DISEASE	☐
MIGRAINES	☐	ANEMIA	☐
DIABETES/GLAUCOMA	☐	CANCER	☐
RHEUMATIC FEVER	☐	JOINT REPLACEMENT/IMPLANT	☐
AIDS OR HIV INFECTION	☐	HEPATITIS/JAUNDICE	☐
CARDIAC PACEMAKER	☐	STOMACH TROUBLES/ULCERS	☐
ASTHMA (INHALER)	☐	SINUS PROBLEMS	☐
FAINTING/SEIZURES	☐	STROKE	☐
THYROID PROBLEM	☐	RADIATION THERAPY	☐
HIGH/LOW BLOOD PRESSURE	☐	RESPIRATORY PROBLEMS	☐
HEART TROUBLE	☐	BONE DISORDER	☐
EPILEPSY/CONVULSIONS	☐	OSTEOPEMIA/OSTEOPOROSIS	☐
TAKING MEDICATION:	☐	REMOVAL OF ADENOIDS/TONSILS	☐

IF SO, SPECIFY: ____________

Dental History

DENTIST ____________

DATE OF LAST CLEANING ____________

	Y	N
1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT?	☐	☐
2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT?	☐	☐
3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐
IF YES, PLEASE DESCRIBE:		
6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:		
A. CHRONIC CLICKING OR POPPING?	☐	☐
B. PAIN?	☐	☐
C. DIFFICULTY OPENING OR CLOSING?	☐	☐
D. DIFFICULTY IN CHEWING?	☐	☐
7. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
9. HAVE YOU EVER HAD SPEECH THERAPY?	☐	☐
IF YES, PLEASE DESCRIBE:		
10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED?	☐	☐
IF YES, PLEASE DESCRIBE:		
11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH?	☐	☐
12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:		
A. NAIL BITING?	☐	☐
B. THUMB SUCKING?	☐	☐
C. TONGUE THRUST WHILE SWALLOWING?	☐	☐
D. MOUTH BREATHING?	☐	☐

13. HOW MANY TIMES A DAY DO YOU BRUSH? ____________

14. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:

CROWDING	☐	**MISSING TEETH**	☐
EXTRA SPACE	☐	**EXTRA PERMANENT TEETH**	☐
TEETH STICK OUT TOO FAR	☐	**TEETH ERUPTING IN THE WRONG POSITION**	☐
TMJ PROBLEMS	☐		
POOR BITE RELATIONSHIP	☐	**OTHER:** ____________	

	Y	N
15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE?	☐	☐

IF SO, WHEN AND BY WHOM? ____________

Please list who we can share information with: ____________

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE MARY KAY KOEN ORTHODONTICS PERMISSION TO PERFORM AN ORTHODONTIC EXAMINATION AND EVALUATION.

SIGNATURE OF PATIENT (OR PARENT IF MINOR) ____________ DATE ____________

PRINT NAME ____________ RELATIONSHIP TO PATIENT ____________