

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, GOODLETTSVILLE, 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 _____	FATHER'S NAME _____
<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> STEPFATHER
DATE OF BIRTH _____ SSN _____	DATE OF BIRTH _____ SSN _____
ADDRESS _____	ADDRESS _____
CITY _____ STATE _____ ZIP _____	CITY _____ STATE _____ ZIP _____
HOW LONG AT THIS ADDRESS? _____	HOW LONG AT THIS ADDRESS? _____
CELL PHONE _____	CELL PHONE _____
WORK PHONE _____	WORK PHONE _____
EMPLOYER _____ YEARS EMPLOYED _____	EMPLOYER _____ YEARS EMPLOYED _____
OCCUPATION _____	OCCUPATION _____
EMAIL _____	EMAIL _____

### Primary Dental 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 Dental 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 \_\_\_\_\_

1. ARE YOU UNDER MEDICAL TREATMENT NOW?  Y  N

2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS?  Y  N

3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?  Y  N  
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? \_\_\_\_\_

4. DO YOU USE TOBACCO?  Y  N

5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS?  Y  N  
IF YES, WHAT? \_\_\_\_\_

6. FEMALES ONLY:  Y  N  
A. HAS MENSTRUATION BEGUN? IF YES, DATE: \_\_\_\_\_  Y  N  
B. ARE YOU PREGNANT, OR THINK YOU MAY BE?  Y  N

7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS?  Y  N  
IF YES, SPECIFY \_\_\_\_\_

8. HAS THE PATIENT REACHED PUBERTY?  Y  N

9. PLEASE CHECK ALL THAT APPLY:

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

IF SO, SPECIFY: \_\_\_\_\_

## Dental History

DENTIST \_\_\_\_\_

DATE OF LAST CLEANING \_\_\_\_\_

1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT?  Y  N

2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT?  Y  N

3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?  Y  N

4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?  Y  N

5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?  Y  N  
IF YES, PLEASE DESCRIBE: \_\_\_\_\_

6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:

A. CHRONIC CLICKING OR POPPING?	<input type="checkbox"/> Y <input type="checkbox"/> N
B. PAIN?	<input type="checkbox"/> Y <input type="checkbox"/> N
C. DIFFICULTY OPENING OR CLOSING?	<input type="checkbox"/> Y <input type="checkbox"/> N
D. DIFFICULTY IN CHEWING?	<input type="checkbox"/> Y <input type="checkbox"/> N

7. DO YOU CLENCH OR GRIND YOUR TEETH?  Y  N

8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?  Y  N

9. HAVE YOU EVER HAD SPEECH THERAPY?  Y  N  
IF YES, PLEASE DESCRIBE: \_\_\_\_\_

10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED?  Y  N  
IF YES, PLEASE DESCRIBE: \_\_\_\_\_

11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH?  Y  N

12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:

A. NAIL BITING?	<input type="checkbox"/> Y <input type="checkbox"/> N
B. THUMB SUCKING?	<input type="checkbox"/> Y <input type="checkbox"/> N
C. TONGUE THRUST WHILE SWALLOWING?	<input type="checkbox"/> Y <input type="checkbox"/> N
D. MOUTH BREATHING?	<input type="checkbox"/> Y <input type="checkbox"/> N

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:

<input type="checkbox"/> CROWDING	<input type="checkbox"/> MISSING TEETH
<input type="checkbox"/> EXTRA SPACE	<input type="checkbox"/> EXTRA PERMANENT TEETH
<input type="checkbox"/> TEETH STICK OUT TOO FAR	<input type="checkbox"/> TEETH ERUPTING IN THE WRONG POSITION
<input type="checkbox"/> TMJ PROBLEMS	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> POOR BITE RELATIONSHIP	

15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE?  Y  N  
IF SO, WHEN AND BY WHOM? \_\_\_\_\_

## 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 CAY KOEN ORTHODONTICS PERMISSION TO PERFORM AN ORTHODONTIC EXAMINATION AND EVALUATION.

SIGNATURE OF PATIENT (OR PARENT IF MINOR) \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

Please list who we can share information with: \_\_\_\_\_