2334 31st Avenue, Suite 1
Rock Island, IL 61201
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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 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 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

Signature

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 (If under 18, have responsible adult person sign)___________________________Date______________