4507 24th Street
Rock Island, IL 61201
Phone: (309) 558-0075
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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_____