Patient Information - Adult

Date ______________________

Patient's Name ______________________ (Last / First / Middle) Prefers to be called ______________

Mailing Address ______________________ (Street / City / State / Zip)

Birthdate ______________ Age ______________ Sex M F

Home Phone ______________ Business Phone ______________ SS # ______________

Marital Status ______________ Names/Ages of Children ______________________

Employer ______________ Occupation ______________________

Are any other members of your family being treated here? If so, who? ______________________

How did you hear about Dr. McFarland? ______________________

Name of Spouse ______________ Employer/Occupation ______________ Business Phone ______________

Spouse's SS# ______________

Responsible Party Information

Name of person responsible for account ______________________ (Last / First / Middle)

Relationship to patient: ______________ If other than those listed above, please complete below:

Residence of person responsible for payment of account ______________________ (Street / City / State / Zip)

How long at this address? ______________ Home Phone ______________ Work Phone ______________

Previous Address (if less than 3 yrs) ______________________ (Street / City / State / Zip)

SS # ______________ Employer ______________ Occupation ______________

No. Years Employed ______________

Dentist Information

Dentist's name ______________________ Date of last visit ______________

Insurance Information

Are you covered by orthodontic insurance? ____ If so, please provide following information so we can verify your coverage:

Insured's Name ______________________ (Last / First / Middle) Insured's SS # ______________

Insurance Company ______________ Group No. ______________ Local No. ______________

Insurance Co. Address ______________________

Do you have dual coverage? Yes No If yes:

Insured's Name ______________________ (Last / First / Middle) Insured's SS# ______________

Insurance Co. ______________ Group No. ______________ Local No. ______________

Insurance Co. Address ______________________

Employer ______________ Telephone number of insurance company ______________

In your own words, what is the problem, or why are you here to see Dr. McFarland today?

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Signature ______________________ Date ______________

I understand that, where appropriate, credit bureau reports may be obtained.

(over)

Health History

Is patient currently under physician's care? Reason: ______________________________

Please check box if you now have or have had:

- ☐ Adenoids removed
- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Asthma
- ☐ Bone disorders
- ☐ Bruxing
- ☐ Cancer treatment
- ☐ Cardiac pacemaker
- ☐ Congenital heart lesions
- ☐ Chronic cough
- ☐ Diabetes
- ☐ Ear problems
- ☐ Emotional problems
- ☐ Endocrine problems
- ☐ Epilepsy
- ☐ Faintness/Dizziness
- ☐ Headaches (frequent)
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ HTLV-III virus
- ☐ Jaundice
- ☐ Joint swelling
- ☐ Kidney treatment
- ☐ Organ transplant
- ☐ Osteoporosis
- ☐ Prolonged bleeding
- ☐ Psychiatric treatment
- ☐ Rheumatic fever
- ☐ Scoliosis
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Swelling ankles
- ☐ TMJ
- ☐ Thyroid problems
- ☐ Tonsils removed
- ☐ Tuberculosis
- ☐ Venereal disease
- ☐ Whiplash

Please check box if answer is YES:

- ☐ Any injuries to face, mouth, teeth? (circle)
- ☐ Thumb, finger, lip sucking? (circle)
- ☐ Mouth-breathing when awake, asleep? (circle)
- ☐ Any missing permanent teeth?
- ☐ Any extra permanent teeth?
- ☐ Any teeth removed by extraction?
- ☐ Is there a tongue-thrust problem?
- ☐ Any speech problems?
- ☐ Any pain or clicking on opening mouth?
- ☐ Has an orthodontist been consulted previously?
- ☐ Reason: ______________________________

List any other serious illnesses ______________________________

List any allergies ______________________________

Temporo-mandibular and Facial Pain Questionnaire

Please circle Y or N on every item in *all* categories below — feel free to ask for assistance if you do not understand a question:

Questionnaire #1

- Y N Does your jaw make noise so that it bothers you or others?
- Y N Does your jaw get stuck so that you can't open it freely?
- Y N Does it hurt when you chew or open wide to take a big bite?
- Y N Do you have earaches or pain in the front of the ears?
- Y N Do you have pain in face, cheeks, jaws, throat, or temples?
- Y N Are you unable to open your mouth as far as you want to?
- Y N Do you suffer from frequent headaches?
- Y N Does your jaw"feel tired" after a big meal or dental visit?
- Y N Are you aware of an uncomfortable or bad bite?
- Y N Are you aware that you grind your teeth at night?
- Y N Do you have the habit of "clamping" or "setting" your teeth?
- Y N Do you have any jaw symptoms or headaches upon waking each morning?
- Y N Must you chew exclusively on one side?
- Y N Have you had a blow to the jaw (trauma)?
- Y N Are you a habitual gum chewer, pipesmoker, or nailbiter?

Questionnaire #2

- Y N Does the pain or discomfort disturb your sleep?
- Y N Does the pain or discomfort interfere with your daily routine or other activities?
- Y N Do you take medication or pills for the pain or discomfort (pain relievers, muscle relaxants, or antidepressants)?
- Y N Does the pain or discomfort affect your appetite?
- Y N Do you find the pain or discomfort extremely frustrating or depressing?

Briefly describe what the pain keeps you from doing. ______________________________

- Y N Do you suffer from arthritis or pain in the joints?
- Y N Do you suffer from nervous stomach or ulcers?
- Y N Do you suffer from colitis?
- Y N Do you suffer from back or neck pain (whiplash)?
- Y N Do you suffer from skin problems or allergies?
- Y N Have you ever been treated for a jaw muscle or joint disorder?
- Y N Are you "double jointed" in *any* of your joints?

Signature ______________________________ Date: ____________

Witness: ______________________________ Date: ____________