Garland McKelvain, D.D.S., M.S.D., INC.

SPECIALIST IN ORTHODONTICS

ABOUT THE PATIENT:

Date: __________

Patient's Name: (First) _______________ (Last)______________________ (MI) _____
Nickname: ________________
Birth date: _____-_____-_____ Age: __________Male _____ Female ______
Address: _____________________________ _______________, ________, ________
(Street) (City) (State) (Zip)
Telephone Number: ______-______-________Home _____-_____-_______Cell

Email address:____

Whom may we thank for referring you? _______________________________________
Have we treated any of your family members? __________
General Dentist: ______________________ Last visit: _____________

PATIENT WORK / INSURANCE INFORMATION

Name: ____________________ Home Telephone Number: ______-______-________
Employer: _________________ Work Telephone Number: ______-______-________
S.S. Number: ______-____-________ Birth date: ______-______-______
Orthodontic coverage: Yes _____ No _____
Insurance Company Name: __________________ ID# ________________
Insurance Telephone # ______-______-_______

SPOUSE'S WORK / INSURANCE INFORMATION

Name: ____________________ Home Telephone Number: ______-______-________
Employer: _________________ Work Telephone Number: ______-______-________
S.S. Number: ______-____-________ Birth date: ______-______-______
Orthodontic coverage: Yes _____ No _____
Insurance Company Name: ________________ID # ___________________
Insurance Telephone # ______-______-________

(PLEASE COMPLETE OTHER SIDE OF FORM)

What are the main concerns that you would like orthodontics to accomplish?
____
____

Please answer yes or no to the following:
Have you ever been evaluated for or had orthodontics before? _____
Have there been any injuries to the face, mouth, teeth, or chin? _____
Have adenoids or tonsils been removed? _____
Have you been informed of any missing or extra permanent teeth? _____
Have you had any pain or tenderness in your jaw bone joint? _____
Have you ever been told by physician to take antibiotics before dental procedures? _____
Are you pregnant? _____

Your physician:___________________________ Telephone # ______-______-_________
Approximate date of last visit: ________________________
Are you currently under the care of a physician? Yes No
Please describe your current physical health: Good Fair Poor
Please list any drugs that you are currently taking: _____________________________
Please list all drugs that you are allergic to: __________________________________

Have you had any of the following medical problems:

Y N Abnormal bleeding
Y N Allergies to any drugs
Y N Allergies to Latex, Metals, Plastics
Y N Any hospital stays
Y N Any operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsion/Epilepsy
Y N Tuberculosis
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N HIV+/AIDS
Y N Hepatitis
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever

Please discuss any of the yes responses above: __________________________________
____

Do you now or have you had any of the following habits?
Y N Clenching/Grinding Teeth
Y N Mouth breathing
Y N Tongue Thrust
Y N Speech Problems
Y N Thumb/Finger Sucking

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my dental or medical condition.
I authorize the dental staff to perform the necessary dental services that I may need.

____ ___________________________
Signature Date