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
E-Mail _____
School: _____ Hobbies: _____
Whom may we thank for referring you? _____
List Siblings and DOB _____
Have we treated any of these children? _____
General Dentist: _____ Last visit: _____

FATHER'S INFORMATION:

Name: _____home _____-_____-_____cell____-____-_____
Employer: _____ Work Telephone Number: _____-_____-_____
S.S. Number: _____-____-_____ Birth date: _____-_____-_____
Orthodontic coverage: Yes _____ No _____
Insurance Company Name: _____ ID#_____
Insurance Telephone # _____-_____-_____

MOTHER'S INFORMATION

Name: _____ home _____-_____-_____cell____-____-_____
Employer: _____ Work Telephone Number: _____-_____-_____
S.S. Number: _____-____-_____ Birth date: _____-_____-_____
Orthodontic coverage: Yes _____ No _____
Insurance Company Name: _____ ID# _____
Insurance Telephone # _____-_____-_____

PERSON RESPONSIBLE FOR ACCOUNT: (If different from above)

Name: _____ Relationship to patient:_____
Billing Address: _____

Home Telephone Number: _____-_____-_____ cell _____-_____-_____

(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:

Has your child ever been evaluated or had orthodontics before? _____
Have there been any injuries to the face, mouth, teeth, or chin? _____
Have adenoids or tonsils been removed? _____
Has your child been informed of any missing or extra permanent teeth? _____
Has your child had any pain or tenderness in his/her jaw bone joint? _____
Has your child ever been told by physician to take antibiotics before dental procedures? _____

Child's physician:_____ Telephone # _____-_____-_____
Approximate date of last visit: _____
Is your child currently under the care of a physician? Yes No
Please describe your child's current physical health: Good Fair Poor
Please list any drugs that your child is currently taking: _____
Please list all drugs that your child is allergic to: _____

Has your child had any of the following medical problems:

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

Please discuss any of the yes responses above: _____
_____

Does your child have any of the following habits?

Y	N	Clenching/Grinding Teeth	Y	N	Speech Problems
Y	N	Mouth breathing	Y	N	Thumb/Finger Sucking
Y	N	Tongue Thrust			

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 child's dental or medical condition.
I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of parent or guardian Date