Members
American Association of
Orthodontists

Welcome to McCranels Orthodontics

ADULT INFORMATION

PLEASE PRINT CLEARLY Date ____ /____ /_____

Patient Name _____ Birthdate _____ Sex ❑ Male ❑ Female
First Middle Last

Preferred Name _____ Hobbies/Interests _____

Home Address _____ Home Phone _____

City _____ Zip _____ Cell Phone _____

Business Address _____ Work Phone _____ Occupation _____

Spouse's Name _____ Cell Phone _____

Business Address _____ Work Phone _____ Occupation _____

Email Address _____

FINANCIAL AND INSURANCE HISTORY

Names of Person Responsible for Account _____ Social Security No. _____

Address *(if different from patient)* _____

Relationship to Patient _____ Marital Status ❑ Married ❑ Divorced ❑ Separated ❑ Single

Do you have dental insurance that covers orthodontic treatment? ❑ Yes ❑ No ❑ Not Sure

Name of Insurance Company _____

Policy Holder Name _____ Birthdate _____ I.D. _____

Monthly payments preferred? ❑ $200 ❑ $300 ❑ $400 ❑ $500 ❑ Payment in full discount

MEDICAL HISTORY

Family physician is _____ Last visit was _____

Is the patient under the care of a physician for a specific problem at this time? ❑ Yes ❑ No If yes, why? _____

_____

List all Allergies _____

List all medications being taken _____

List any accidents, illnesses, or operations _____

If female, are you or might you be pregnant? ❑ Yes ❑ No

PLEASE CHECK THE FOLLOWING; IF THEY APPLY:

❑ Contact Lenses	❑ High Blood Pressure	❑ Asthma	❑ HIV or AIDS
❑ Glaucoma	❑ Head or Facial Injury	❑ Rheumatic fever	❑ Speech Problems
❑ Heart Trouble	❑ Tonsillitis	❑ Diabetes	❑ Emotional Problems
❑ Kidney Disease	❑ Hearing Problems	❑ Bleeding Problems	❑ Endocrine Problems
❑ Hepatitis/Liver Disease	❑ Heart Murmur	❑ Epilepsy	❑ Nervous Problems

DENTAL HISTORY

Family Dentist is _____ Last visit was _____

Have there been any injuries to face, mouth, or teeth? _____ ❑ Yes ❑ No

Has there ever been pain or clicking around your ears or jaw joint? _____ ❑ Yes ❑ No

Has patient ever sucked thumb or fingers? (how long?) _____ ❑ Yes ❑ No

Has an orthodontist been consulted before? (how long ago?) _____ ❑ Yes ❑ No

Has there been any type of orthodontic treatment? (when and what kind?) _____ ❑ Yes ❑ No

Have you ever been informed of any missing or extra teeth? _____ ❑ Yes ❑ No

Please list any family members that have been seen at this office. _____

In your words, what don't you like about your teeth? _____

Who can we thank for referring you to our office? _____

Thank you for your time

_____
Patient's Signature