Patient Information: Child

Date: _____

Patient's name: _____ (LAST / FIRST / MIDDLE) Prefers to be called: _____

Mailing address: _____ (STREET / CITY / STATE / ZIP)

Birth date: _____ Age: _____ Grade: _____ School: _____ Gender: ❑ M ❑ F

Home phone: _____ E-mail: _____

Other family members treated here? If so, who? _____ How did you hear of Dr. McFarland? _____

Names & birth dates of siblings: _____

Responsible Party Information

Father's name: _____ (LAST / FIRST / MIDDLE) ❑ Natural ❑ Step

Address: _____ (STREET / CITY / STATE / ZIP) Home phone: _____

How long at this address: _____ Employer/occupation: _____ Business phone: _____

Number of years employed: _____ SS#: _____ Birth date: _____

Mother's name: _____ (LAST / FIRST / MIDDLE) ❑ Natural ❑ Step

Address: _____ (STREET / CITY / STATE / ZIP) Home phone: _____

How long at this address: _____ Employer/occupation: _____ Business phone: _____

Number of years employed: _____ SS#: _____ Birth date: _____

Insurance Information

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

Insured's name: _____ (LAST / FIRST / MIDDLE) Insured's SS#: _____

Insurance company: _____ Group number: _____ Local no: _____

Insurance company address: _____

Employer: _____ Insurance company phone: _____

Do you have dual coverage? ❑ Yes ❑ No If yes, please complete the following:

Insured's name: _____ (LAST / FIRST / MIDDLE) Insured's SS#: _____

Insurance company: _____ Group number: _____ Local no: _____

Insurance company address: _____

Employer: _____ Insurance company phone: _____

Dentist Information

Dentist's name: _____ Date of last visit: _____

Dentist's address: _____

Emergency Information

Name of nearest living relative not living with you: _____ Phone: _____

Complete address: _____ (STREET / CITY / STATE / ZIP)

Signature: _____ Date: _____

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

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 Valve
- ❑ 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* (see below)
- ❑ Thyroid problems
- ❑ Tonsils removed
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Whiplash

Please check box if any 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:

_____

_____

_____

In your own words, what is the problem: _____

List any other serious illnesses: _____

List any allergies: _____

Temporo-mandibular and Facial Pain Questionnaire

***Please circle Y or N in every item in ALL categories below if you checked TMJ above.**

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 front of the ears?
Y N Do you have pain in face, cheeks, jaw, throat, or temples?
Y N Are you able 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 eating a big meal or dental visit?
Y N Are you aware of an uncomfortable or bad bite?

QUESTIONNAIRE #2

Y N Are you aware that your teeth grind 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, pipe smoker, or nail biter?

QUESTIONNAIRE #3

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, antidepression pills)?
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: _____

_____

QUESTIONNAIRE #4

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: _____