

O'Neill Orthodontics

Nancy L. O'Neill, DDS, MS

Patient's Name _____ Date Of Birth _____ Age _____

Referred By _____ Dentist _____ Phone # _____

Father's Name _____ DOB _____ SS# _____

Mother's Name _____ DOB _____ SS# _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

E-mail Address: _____

Address: _____ City _____ State _____ Zip Code _____

Chief Concern: _____

Previous orthodontic consultation _____

Family member had orthodontic treatment _____

Is patient enthusiastic and sincere about getting orthodontic Treatment _____

Tonsils removed _____ What age _____

Adenoids removed _____ What age _____

Mouth Breather _____ Awake _____ Asleep _____ Both _____

Discomfort/Noise when opening or closing mouth _____

Any musical instruments _____ What _____

Teeth brushed daily _____ How often _____

Floss used _____ How often _____

Past facial or mouth injuries _____

Unfavorable reactions to drugs _____ What _____

Medication being taken now _____ What _____

Are you under a physician's care now _____ What _____

Date of last dental check-up _____

Discuss Treatment Plan with / without child present.
(Circle Choice)

Insurance information if Applicable

Policy holder _____

Employer _____

Insurance Company _____

Policy # _____

Does the patient have or has the patient had the following:

Condition	Yes	No	Condition	Yes	No
Rheumatic Fever			Antibiotics taken Prior to Surgery/ Dental appts.		
Heart condition			Problem chewing		
Diabetes			Problem swallowing		
Anemia			Problem breathing		
Pneumonia			Fainting		
Neurological Condition			Bleeding Problem		
Hepatitis			Ever taken Phen/Fen		
Epilepsy			Drug Alcohol Abuse		
Asthma			Attention Problem		
Tuberculosis			Cold Sores		
Speech problem			Smoking		
HIV					
Measles					
Mumps					
Chicken pox					
Cancer					
Allergies What:::			Other:		

Does the patient have or has the patient had the following:

	Now	Past	Age Stopped
Tongue thrust			
Lip: Wedging < Biting <			
Sucking: Fingers < Thumb < Pacifier <			
Biting: Nails < Pencil < Other <			
Grind: Awake < Asleep <			
Swallowing Lips pursed < Head Nod < Unusual effort <			
TMJ Problems			
Other:			

Parent / Patient Signature

Date