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**