Nancy L. O'Neill, DDS, MS
180 Fairview Court, New Freedom, PA 17349

Patient's Name:_____ Date of Birth:___/___/_____ Age: _____

Address _____City _____State _____ Zip Code_____

Phone (Mom)_____ Phone (Dad) _____ Work Phone:_____

E-mail Address:_____ Home Phone: _____

(Parent information not applicable for adult patients)

Father's Name_____ DOB ___/___/_____ SS#_____

Mother's Name_____ DOB ___/___/_____ SS#_____

Dentist: _____ Phone :_____ Last seen ___/ ___/_____

Physician : _____ Phone: _____ Last seen ___/___/_____

Chief orthodontic concern: _____ O Second Opinion

Any previous orthodontic treatment? _____

Is the patient enthusiastic about orthodontic treatment? _____

Other family members treated here? _____

Is patient involved in … Sports? _____ Play an Instrument? _____

School attending / Home schooled ? _____

How did you hear of " O'Neill Orthodontics" _____

Dental Insurance Information

Policy Holder: _____DOB __/__/_____ Subscriber ID#_____

Dental Insurance Company Name:_____ Group #_____

Employer: _____ Policy Effective Date: _____

Secondary Dental Insurance:

Policy Holder: _____DOB __/__/_____ Subscriber ID#_____

Dental Insurance Company Name:_____ Group #_____

Employer: _____ Policy Effective Date: _____

DENTAL HISTORY

For the following questions circle Yes, No, or don't know/understand (DK/U).

Now or in the past, has the patient had:

Yes No DK/U Started teething very early or late?
Yes No DK/U Primary (baby) teeth removed that were not loose?
Yes No DK/U Permanent or "extra" (supernumerary) teeth removed?
Yes No DK/U Supernumerary (extra) or congenitally missing teeth?
Yes No DK/U Chipped or otherwise injured primary (baby) or permanteeth?
Yes No DK/U Teeth sensitive to hot or cold; teeth throb or ache?
Yes No DK/U Jaw fractures, cysts or mouth infections?
Yes No DK/U "Dead teeth" or root canals treated?
Yes No DK/U Bleeding gums, bad taste or mouth odor?
Yes No DK/U Periodontal "gum problems"?
Yes No DK/U Food impaction between teeth?
Yes No DK/U Thumb, finger, or sucking habit? Until what age ?
Yes No DK/U Abnormal swallowing habit (tongue thrusting)?
Yes No DK/U History of speech problems?
Yes No DK/U Mouth breathing habit, snoring or difficulty in breathing?
Yes No DK/U Tooth grinding, jaw clenching clicking or locking?
Yes No DK/U Any pain in jaw or ringing in the ears?
Yes No DK/U Any pain or soreness in the muscles of the face or around the ears?
Yes No DK/U Difficulty encountered in chewing or jaw opening?
Yes No DK/U Aware of loose, broken or missing restorations (fillings)?
Yes No DK/U Any teeth irritating cheek, lip, tongue or palate?
Yes No DK/U Concerned about spaced, crooked or protruding teeth?
Yes No DK/U Aware or concerned about under or over developed jaw?
Yes No DK/U "Gum Boils", frequent canker sores or cold sores?
Yes No DK/U Taking any forms of fluoride?
Yes No DK/U Any relative with similar tooth or jaw relationships?
Yes No DK/U Had periodontal (gum) treatment?
Yes No DK/U Would patient object to wearing orthodontic appliances (braces) should they be indicated?
Yes No DK/U Any serious trouble associated with any previous dental treatment?
Yes No DK/U Ever had a prior orthodontic examination or treatment?
Yes No DK/U Been under another dentist's care? _____

For the following questions circle Yes, No, or don't know/understand (DK/U)
The answers are for office records only and will be considered confidential.
A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

Yes No DK/U Does patient follow directions well?
Yes No DK/U Does patient brush his/her teeth meticulously?
Yes No DK/U Does patient have learning disabilities or need extra help with instructions?
Yes No DK/U Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, has the patient had:

Yes No DK/U Birth defects or hereditary problems?
Yes No DK/U Bone fractures, any major accidents?
Yes No DK/U Rheumatoid or arthritic conditions?
Yes No DK/U Endocrine or thyroid problems?
Yes No DK/U Kidney problems?
Yes No DK/U Diabetes?
Yes No DK/U Cancer, tumor, radiation treatment or chemotherapy?
Yes No DK/U Stomach ulcer or hyperacidity?
Yes No DK/U polio, mononucleosis, tuberculosis or pneumonia?
Yes No DK/U Problems of the immune system?
Yes No DK/U AIDS or HIV positive?
Yes No DK/U Hepatitis, jaundice or liver problem?
Yes No DK/U Fainting spells, seizures, epilepsy or neurological problem?

Yes No DK/U Mental health disturbance or behavioral problem?
Yes No DK/U Vision, hearing, tasting or speech difficulties?
Yes No DK/U Loss of weight recently, poor appetite?
Yes No DK/U History of eating disorder (anorexia, bulimia)?
Yes No DK/U Excessive bleeding or bruising tendency, anemia Or bleeding disorder?

Yes No DK/U High or low blood pressure?
Yes No DK/U Tires easily?
Yes No DK/U Chest pain, shortness of breath or swelling ankles?
Yes No DK/U Cardiovascular problem (heart trouble, heart attack, angina ,coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

Yes No DK/U Skin disorder?
Yes No DK/U Does the patient eat a well-balanced diet?
Yes No DK/U Frequent headaches, colds or sore throats?
Yes No DK/U Eye, ear, nose or throat condition?
Yes No DK/U Hayfever, asthma, sinus trouble or hives?
Yes No DK/U Tonsil or adenoid conditions?

ALLERGIES OR REACTIONS TO:

Yes No DK/U Local anesthetics (Novocain or Lidocaine)
Yes No DK/U Aspirin
Yes No DK/U Ibuprofen (Motrin, Advil)
Yes No DK/U Penicillin or other antibiotics
Yes No DK/U Sulfa drugs
Yes No DK/U Codeine or other narcotics
Yes No DK/U Metals (jewelry, clothing snaps)
Yes No DK/U Latex (gloves, balloons)
Yes No DK/U Vinyl
Yes No DK/U Acrylic
Yes No DK/U Animals
Yes No DK/U Foods (specify) _____
Yes No DK/U Other substances (specify) _____
Yes No DK/U Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

Yes No DK/U Does the patient currently have or ever had a substance abuse problem?
Yes No DK/U Does the patient chew or smoke tobacco?
Yes No DK/U Operations? Describe: _____
Yes No DK/U Hospitalized? For:_____
Yes No DK/U Other physical problems or symptoms? Describe: _____

Yes No DK/U Being treated by another health care professional? For:_____

Are there any other medical conditions that we should be aware of?

_____
_____
_____

GIRLS ONLY

Yes No DK/U Has the patient started her monthly periods?
If yes, at what age? _____

I have read and understand the above questions. I will not hold Nancy O'Neill DDS or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this medical/dental history record I will so inform Nancy L. O'Neill, DDS/ O'Neill Orthodontics.

_____ _____
Parent / Guardian signature Date

I hereby instruct and direct my insurance company to pay the dental expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered, directly to O'Neill Orthodontics / Nancy L. O'Neill, DDS. Insurance benefit estimates are not a guarantee of payment.

Patient copays are an estimate and I am responsible for any unpaid balance.

_____ _____
Parent or Guardian signature Date