Welcome to our office

Ernest H. McDowell, D.M. D.

McDowell Orthodontics

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Member American Association of Orthodontists
Diplomates American Board of Orthodontics
Invisalign 2014 Elite Top 1% Provider
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NEW PATIENT REGISTRATION FORM

(FOR PATIENTS UNDER AGE 18)

The information provided is strictly confidential

Please Print Legibly

PATIENT INFORMATION

Today's Date: ________________

TELL US ABOUT YOUR CHILD

Name:____
Last First MI

Nickname:________________________ ___Male ___Female

Birthdate:__/__/___Age:___SS#:_______________________

Home Address:_______________________________________
City State ZIP

School:___________________________Grade:____________

Hobbies/Sports:______________________________________

PARENTS' INFORMATION

Parents' Marital Status

____Single____Married____Divorced____Widowed____Separated

Mother's Information ____Step Mother_____Guardian

Name:______________________________Birthdate:___/___/_______
Home #: (__)______________Work #: (__)______________Ext.:____
Email:_______________________________SS #:________________
Employer: ____
Employer's Address: _____________________________________
How long there?________Occupation:_______________________

Father's Information _____Step Father_____Guardian

Name:______________________________Birthdate:___/___/_______
Home #: (__)______________Work #: (__)______________Ext.:____
Email:_______________________________SS #:________________
Employer:____
Employer's Address:______________________________________
How long there?________Occupation:_______________________

GENERAL INFORMATION

General Dentist:____
Last Visit Date:____
List brothers/sisters, with ages:____________________________
____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name:______________________Relation:______________
Do you have legal custody of this child? _______Yes_______No

Whom may we thank for referring you?

____

ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage:_Yes_No Dental Coverage:_Yes_No
Ins. Co. Name:____
Ins. Co. Address:____
Ins. Co. Phone: (___)______________________________________
Group # (Plan, Local, or Policy #):___________________________
Insured's Name:____________________ Relation:____________
Insured's D.O.B.:___/___/______Insured's ID #:_____________
Insured's Employer:___________________________

SECONDARY

Orthodontic Coverage:_Yes_No Dental Coverage:_Yes_No
Ins. Co. Name:____
Ins. Co. Address:____
Ins. Co. Phone: (___)______________________________________
Group # (Plan, Local, or Policy #):___________________________
Insured's Name:____________________ Relation:____________
Insured's D.O.B.:___/___/______Insured's ID #:_____________
Insured's Employer:_______________________________________

PERSON RESPONSIBLE FOR ACCOUNT

Name:____
Best Contact #:____
Billing Address:____
Relation:____

EMERGENCY CONTACT

Name:____
Relation:____
Home #:____
Work #:____

MEDICAL HISTORY

Your child's current health is: Good ___Fair ___Poor
Does your child have a personal physician? ___Yes ___No
Physician's Name:________________________________
Phone #: (___)________________Date of last visit:______________
Is your child currently under the care of a physician? ___Yes ___No
Please explain:________________________________
Is your child taking any prescription/over-the-counter drugs?_Yes_No
Please list each one:________________________________
Has puberty begun? ___Yes ___No
Has menstruation begun? ___Yes ___No

Has your child ever had any of the following diseases or medical problems?

- Y N Abnormal Bleeding
- Y N Anemia
- Y N Artificial Bones/Joints/Valves
- Y N Asthma/Arthritis
- Y N Blood Transfusion
- Y N Cancer/Chemotherapy
- Y N Diabetes
- Y N Difficulty Breathing/Snoring
- Y N Drug/Alcohol Abuse
- Y N Emphysema
- Y N Epilepsy/Seizures/Fainting
- Y N Glaucoma
- Y N Heart Attack
- Y N Heart Murmur
- Y N Heart Surgery/Pacemaker
- Y N Hemophilia
- Y N Hepatitis
- Y N High/Low Blood Pressure
- Y N HIV/AIDS
- Y N Hospitalized for Any Reason
- Y N Kidney Problems
- Y N Mitral Valve Prolapse
- Y N Psychiatric Problems
- Y N Radiation Treatment
- Y N Rheumatic/Scarlet Fever
- Y N Severe/Frequent Headaches
- Y N Shingles
- Y N Sickle Cell Disease/Traits
- Y N Tuberculosis (TB)
- Y N Ulcers
- Y N Colitis
- Y N Venereal Disease

Is your child allergic to any of the following?

- Y N Aspirin
- Y N Any Metals/Plastics
- Y N Codeine
- Y N Dental Anesthetics
- Y N Erythromycin
- Y N Latex
- Y N Penicillin
- Y N Tetracycline
- Y N Other

Please list any other drugs/materials you are allergic to:____________
____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?________________________________
____
Has your child ever had or been evaluated for orthodontic treatment?__Y_N
Has your child ever had a serious/difficult problem associated with any previous dental work? ___Yes ___No
Has your child ever experienced pain/discomfort in their jaw joint (TMJ/TMD)? ___Yes ___No
Your child's current dental health is:__Good__Fair__Poor
Do your child's gums ever bleed? ___Yes ___No
Has he/she ever had an injury to his/her: __Mouth__Teeth__Chin
Does your child have any missing or extra permanent teeth? _Y_N
Has he/she ever taken Fosamax, or any other bisphosphonate?_Y_N
Has your child ever taken Phen-Fen? ___Yes ___No

Has your child ever experienced any of the following?

- Y N Clenching/Grinding Teeth
- Y N Lip Sucking/Biting
- Y N Mouth Breathing
- Y N Nail Biting
- Y N Nursing Bottle Habits
- Y N Speech Problems
- Y N Thumb/Finger Sucking
- Y N Tongue Thrust

Child's Sleep Behavior:

Does your child frequently snore? ___Yes ___No
Does your child frequently grind their teeth during sleep? ___Yes ___No
Does your child seem tired during the daytime? ___Yes ___No

INFORMATION & CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____
Signature Date

CONSENT TO THE USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, publication in professional journals, scientific papers, demonstration or marketing purposes. In addition, when i-CAT images are taken, Dr. McDowell will interpret only those areas consistent with a 2D panorex or ceph. The patient is welcome to have these images further diagnosed by a radiologist for more details at their cost.

____
Signature Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian of the patient named herein. Initials:______________Date:_________

Doctor's Comments:________________________________
____