Christopher J. McTavish DMD, MS

Patient Information: *Please Complete This Page Only*

Patient Name: _____Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____State: _____ Zip Code: _____

Referred by: _____ School: _____Grade: _____

Dentist: _____ Physician: _____

Family members who have had orthodontic treatment at this office: _____

Why are you seeking orthodontic care? _____

Have you seen another orthodontist? ( ) Yes ( ) No If yes, were x-rays taken? _____

Mother/Spouse's name: _____Address: _____

Primary Phone: ( ) _____ Alt. Phone: ( ) _____ **Email**: _____

Father/Spouse's name: _____ Address: _____

Primary Phone: ( ) _____ Alt. Phone: ( ) _____ **Email**: _____

Medical History

Presently under medical care for: _____

Medication being taken now (Name and Dosage): _____

Medication or material allergy: _____

PLEASE ANSWER ALL OF THE FOLLWING QUESTIONS:

	Yes	No		Yes	No		Yes	No		Yes	No
Adenoids removed			Cerebral Palsy			Hospitalized			Rheumatic Fever		
Allergies			Diabetes			Hypertension			Speech Problems		
Anemia			Dizziness			Infectious Disease			Tonsils Removed		
Arthritis			Emotional			Jaundice					
Asthma			Epilepsy			Kidney Disorder			**Male:**	**Yes**	**No**
Birth Defects			Eye Disorders			Liver Disorder			Voice changed		
Blood Disorder			Hearing Problems			Lung Disorder			When? (Year)		
Bone Disorder			Heart Disorder			Nosebleeds			**Female**	**Yes**	**No**
Bronchitis			Hepatitis			Osteoporosis			Began menstruation		
Cancer			HIV			Pregnant			When? (Year)		

Please give additional details where necessary: _____

Dental History

Injuries or trauma to the face or teeth: _____

Thumb/Finger Sucking Habit: Yes ( ) No ( ) Other habits: (i.e. lip or nail biting) _____

Frequent Infections: Ear _____ Nose _____ Throat _____ Patient breathes through: Nose _____ Mouth _____ Both _____

Problems with Jaw Joint (TMJ): _____

Problems with teeth or gums: _____

Doctor Initial's:_____

Date: _____/_____/_____

***** Your signature below indicates you have read the office HIPAA Privacy Form.***

Parent/Guardian or Patient Signature: _____ **Date**: _____