BENKO ★ McGROGAN
ORTHODONTICS

Patient Information

A B C

Date ______________________ Dentist ______________________ B K B M

Patient's Name(Last,First, Middle) ______________________

Address(Street, City, State, Zip) ______________________

Home Phone ______________ Birthdate ______________ Social Security # ______________

School ______________ Grade ______________ Interests ______________

Siblings(Name and Age) ______________________

In Case of emergency contact ______________ Phone ______________ Relationship ______________

Responsible Party Information

Custodial Parent's Name(Last,First, Middle) ______________________ ______________
Marital Status

Residence(Street, City, State, Zip) ______________________

Mailing Address(Street, City, State, Zip) ______________________

How Long at this Address ______________ Home Phone ______________ Work Phone ______________

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________________ Number Years Employed ______________

Parent/Spouse's Name(Last,First, Middle) ______________________ Relationship to Patient ______________

Address(Street, City, State, Zip) ______________________

Employer ______________________ Number Years Employed ______________

Social Security # ______________ Birthdate ______________ Work Phone ______________

Orthodontic Insurance Information

Insured's Name ______________________ Insured's Social Security # ______________

Insurance Company ______________ Group Number ______________ Birthdate ______________

Insurance Company Address ______________________

Do you have dual coverage? (circle one) YES NO If yes:

Insured's Name ______________________ Insured's Social Security # ______________

Insurance Company ______________ Group Number ______________ Birthdate ______________

Insurance Company Address ______________________

Insured's Employer ______________________

Dental History

	Chief Concern	Date of last dental visit?

Past dental facial trauma	Yes No	Major accidents or surgery involving the face, neck, mouth or teeth?	Teeth broken, loosened or knocked out?	Missing Teeth		
Jaw joint problems	Yes No	Locking	Pain	Noise	Discomfort Opening or closing	Frequent headaches / Clenching or grinding
Oral problems	Yes No	Canker/cold sores	Swollen/bleeding gums	Hepatitis	Habits Thumb/finger	Speech / Mouth Breathing Day ☐ Night ☐
Difficulty chewing or swallowing food?	Yes No	Previous orthodontic treatment or consultations? Yes No		Orthodontist		Outcome
Siblings had orthodontics?	Yes No	Name/Stage of treatment				
Parents had orthodontics?	Yes No	Mother Father		Orthodontist	Results	Does patients stature, teeth or mouth resemble: M F Neither

Does anyone else in the family have a similar dentofacial condition:
Crowded, retruded or protruded teeth, protruding lower jaw, receding chin?

Medical History

	Present Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐	Physician:

Hospitalized in the past 3 years?	Yes No	Operations	Tonsils or Adenoids	Other
Chronic diseases?	Yes No	(lungs, liver, kidney, heart, etc.)		
Presently under the care of a physician?	Yes No	(diabetes, hepatitis, high/low blood pressure, etc.)		
Presently under medication?	Yes No	Medication:	Prescribed for:	
Allergies:	Yes No	Describe:		
Complications to previous treatment?	Yes No	(excessive bleeding, fainting, drug reaction?)		
Does the patient smoke?	Yes No	Or use any tobacco products? Yes No		

Any diseases or condition or problems the orthodontists should know about?

Has the patient ever had any of the following conditions?

- ☐ AIDS/HIV+
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Heart Murmur
- ☐ Epilepsy
- ☐ Congenital Heart Defect
- ☐ TB
- ☐ Hemophilia
- ☐ Venereal disease
- ☐ Emotional Problems

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's/Guardian's signature if minor) ____________________

Whom may we thank for referring you to our office? ____________________