

Richard E. McClung, DDS, MS
Jennifer Hamilton, DDS, MS
(304) 645-2088

Date: _____

Name: _____
Last First Middle

Nickname: _____ Date of Birth: _____

Age: _____ Sex: _____

Home Address: _____ Home Phone: _____
_____ E-mail: _____

Hobbies: _____

Marital Status(circle one): Married Divorced Widowed Single

Employer: _____

Employer's Address: _____

Occupation: _____ How long there? _____

Work Phone: _____ Work e-mail: _____

Spouse: _____ Occupation: _____

Employer: _____ Work Phone: _____

In the event we must reach you during the work day, is it permissible to call you at work?
Yes No Or what is the best way to contact you? _____

Orthodontic Insurance Coverage? **Yes No** Insurance Company _____

Other family members treated by us? _____

Who referred you to our office? _____

Family Health Team:

Family Dentist: _____ Physician: _____

Oral Surgeon: _____ Pharmacy: _____

Do you or have you ever been informed that you have any of the following habits?

Yes No	Clenching/ grinding teeth	Yes No	Speech problems
Yes No	Lip sucking/ nail biting	Yes No	Thumb/ finger sucking
Yes No	Mouth breathing	Yes No	Tongue thrust

Medical History

Are you in good health today? **Yes No**
Do you have any history of major illnesses? **Yes No**
Have your tonsils and/or adenoids been removed? **Yes No**
Have you ever been under the care of a physician for illness? **Yes No**
Do you have a tendency for Colds? Sore throats? Ear infections?
List any prescription and/or over-the-counter drugs now being taken.

List any allergies or drug sensitivities. _____
For women: Are you pregnant? **Yes No** Taking birth control pills? **Yes No**

Have you ever had any of these problems?

Yes No Abnormal bleeding **Yes No** Diabetes
Yes No Allergy to drugs **Yes No** Handicaps/disabilities
Yes No Allergy to latex/ metal **Yes No** Hearing impairment
Yes No Allergy to plastic **Yes No** Heart murmur
Yes No Any hospital stays **Yes No** Hemophilia
Yes No Any operations **Yes No** Hepatitis
Yes No Asthma **Yes No** HIV +/- AIDS
Yes No Cancer **Yes No** Kidney/ liver problems
Yes No Congenital heart defect **Yes No** Tuberculosis (TB)
Yes No Convulsion/ epilepsy **Yes No** Anything you would like to
discuss in private

Please discuss any medical problems you think we should know.

Are you a smoker? **Yes No**

Dental History

What concerns lead you to seek an orthodontic evaluation?

Do you require antibiotic coverage before dental treatment? **Yes No**
Have you ever been evaluated or had orthodontic treatment before? **Yes No**
Have you had any injuries to the face, mouth, or teeth? **Yes No**
Have you ever been informed of any extra or missing teeth? **Yes No**
Have either parent had orthodontic treatment? **Yes No**

I understand that the information that I have given is correct to the best of my knowledge, that it will be kept confidential, and that it is my responsibility to inform this office of changes in my child's medical or dental status. I authorize the orthodontic staff to perform the necessary dental/ orthodontic services I may need.

Signature: _____ **Date:** _____

Drs. McClung and Hamilton occasionally give lectures and presentations to consulting dentists, orthodontists, and other health care professionals. The materials used may include patient histories, photos, and x-rays. Complete patient privacy would be maintained and information would be anonymous. Your signature below would allow them to use your orthodontic records for educational use only.

Signature: _____ **Date:** _____