Thomas F. Mooney, III, DDS, MDS

Welcome! Our specialty is creating smiles and to do this we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.

636-970-4700
www.ShowMeSmiles.com
4braces@ShowMeSmiles.com

Patient Information

How did you hear about our office? ______________________________

Patient's Name ______________________________ Nickname ______________
Last First Middle

Address ______________________________ Age ______________
Street City State Zip

Home Phone ( )_______-__________ Email ______________ Birth Date ______________

If patient is a minor, give parent's or guardian's name ______________________________

School ______________________________ Grade______________

Siblings/Children YES/NO Name/DOB ______________ Name/DOB ______________

Responsible Party Information

Name ______________________________ Birth Date ______________
Last First

Relationship to Patient ______________ Marital Status ______________

Address ______________________________ How long at address ______________
Street City State

Home Phone ( )_______-__________ Cell Phone ( )_______-__________ Email ______________

Employer ______________ Occupation ______________ # Years Employed ______________

Employer's Address ______________________________ Work Phone ( )_______-__________

Spouse's Name ______________________________ Birth Date ______________
Last First

Work Phone ( )_______-__________ Cell Phone ( )_______-__________ Email ______________

Employer ______________ Occupation ______________ # Years Employed ______________

Orthodontic Insurance Information

PRIMARY INSURED'S NAME ______________________________ Insured's Social Security # ______________

Insured's Primary Address ______________________________

Insurance Company ______________ Group No. ______________ Local No. ______________

Insurance Company Address ______________________________

Insurance Company Phone ( )_______-__________ Fax ( )_______-__________ Dual Coverage YES NO

SECONDARY INSURED'S NAME ______________________________ Insured's Social Security # ______________

Insured's Primary Address ______________________________

Insurance Company ______________ Group No. ______________ Local No. ______________

Emergency Contact Information

Name of nearest relative not living with you ______________________________ Relationship ______________

Address ______________________________ Phone ( )_______-__________
Street City State

CONFIDENTIAL (for record and pre-treatment evaluation)

Medical History

Physician ______________________________ Date of last visit ______________________

Address ______________________________________ Phone (   )_______-____________

Street City State Zip

Please circle YES or NO (if YES, please fill in details)

YES NO Are you taking any medications? ____________________

YES NO Are you allergic to any medications? ____________________

YES NO Do you have a history of major illness? ____________________

YES NO Have you had any major operations? ____________________

YES NO Have you ever been involved in a serious accident? ____________________

YES NO Have you ever taken Fen-Phen? ____________________

YES NO Are you now or have you ever taken bisphosphonates? ____________________

Check any of the medical conditions below that you have had or currently have:

- ☐ Y ☐ N AIDS/HIV+
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma or Hayfever
- ☐ Y ☐ N Bone Disorder
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Dizziness
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Gastrointestinal Disorders
- ☐ Y ☐ N Heart Problems
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes/Cold Sores
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Kidney Disorder
- ☐ Y ☐ N Latex Allergy
- ☐ Y ☐ N Liver Disorder
- ☐ Y ☐ N Metal Allergy
- ☐ Y ☐ N Nervous Disorder
- ☐ Y ☐ N Pneumonia
- ☐ Y ☐ N Prolonged Bleeding
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ____________________

____

If child, have you reached puberty? Girls – have you started menstruation? YES NO Boys – has your voice changed? YES NO

Dental History

Dentist ______________________________ Date of Last Visit ______________________

Address ______________________________________ Phone (   )_______-____________

Street City State Zip

What concerns you most about your teeth? ____________________

YES NO Are you presently in any dental pain? ____________________

YES NO Have you ever experienced any unfavorable reaction to dentistry? ____________________

YES NO Have you ever lost or chipped any teeth? ____________________

YES NO Have you ever had any injuries to mouth or chin? ____________________

YES NO Do your gums bleed when you brush? How often do you brush? ____________________

YES NO Any habits affecting the mouth or teeth? ☐ Thumb Sucking ☐ Nail Biting ☐ Other ____________________

YES NO Are you a mouth breather? While awake? YES NO While asleep? YES NO

YES NO Have you ever seen an Orthodontist? ____________________

YES NO Has anyone in the family received orthodontic treatment? How did they feel about the result? ____________________

What is your attitude toward receiving orthodontic treatment? ____________________

YES NO Do you have any pain or soreness around your face, neck or back? ____________________

YES NO Are you aware of your jaw clicking or popping? ____________________

YES NO Are you aware of clenching your teeth during the day? ____________________

Y ES NO Have you ever been told you grind your teeth? ____________________

YES NO Do you have recurring headaches? ____________________

YES NO Are you aware that some appointments will be during school/work hours? ____________________

For the best outcome to your treatment, please be sure to share all of your health history with us.

Orthodontics is a service that provides an improvement in the appearance, general function, and health of the teeth. Teeth, gums, and jaws can fail to respond to treatment. If good oral hygiene is not practiced during treatment tooth decay, discoloration and enlarged gums can result. Joint discomfort and root shortening are unavoidably observed in a small percentage of cases. Teeth change throughout our lifetime and therefore ongoing movement of teeth after treatment is normal. This will be exacerbated if retainers are discontinued or not worn properly

I hereby state that I have read and understand the above paragraph and that I have truthfully, to the best of my ability, answered all the above questions. If there is any change in my/or my child's medical status I will inform the orthodontist.

______________________ ________ ______________________ ________

Patient/Parent Date Orthodontist Signature Date

Reviewed with patient by ____________________ Updated__________ Initials__________