Welcome to Our Practice!

Orthodontic Questionnaire

Today's Date ___/___/___

PATIENT DATA

Responsible Party ☐ *Yes* ☐ *No*

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Dr

Name _____

Address _____

City/St Zip _____

Phone # (___) _____ SS # _____

Birth Date ___/___/___ Age ___ Sex ___

RESPONSIBLE PARTY INFORMATION

How long at current address? _____

Previous Address _____

(if less than 3 years) _____

_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer _____

Work Phone (___) _____

Occupation _____

How long at current job? _____

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT:

Relationship to patient _____

Name _____

Address _____

City/St Zip _____

Phone # (___) _____ SS # _____

Birth Date ___/___/___ Age ___ Sex ___

DENTAL INSURANCE

Insurance Company _____

Address _____

City/St Zip _____

Phone # (___) _____

Insured's Employer _____

_____

_____

ORTHODONTIC COVERAGE ☐ Yes ☐ No

Insured's Name _____

Insured's SS # _____

Relationship to Patient _____

POLICY NUMBER _____

OTHER INSURANCE

Insurance Company _____

Address _____

City/St Zip _____

Phone # (___) _____

Insured's Employer _____

_____

TYPE of INSURANCE _____

Insured's Name _____

Insured's SS # _____

Phone # (___) _____

Relationship to Patient _____

POLICY NUMBER _____

PATIENT INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

_____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: _____

PHONE # _____

FAMILY PHYSICIAN _____

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE PAST 9 MONTHS

PRACTITIONER	SPECIALTY	APPROXIMATE DATE OF TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

REASON FOR VISIT

- ❑ Accident
- ❑ "Buck" or Protruding Teeth
- ❑ Clicking of Jaw Joint
- ❑ Crowded Teeth
- ❑ Facial Pain
- ❑ Gum Disease or Recession
- ❑ Head Pain
- ❑ Irregular Facial Proportions
- ❑ Irregularly Shaped Teeth
- ❑ Jaw Dysfunction
- ❑ Jaw Pain
- ❑ Mismatched Bite
- ❑ Missing Tooth
- ❑ Missing Teeth
- ❑ Neck Pain - Frequent
- ❑ Orthodontic Second Opinion
- ❑ Overbite
- ❑ Overly Small Mouth
- ❑ Prominent Jaw
- ❑ Receded Jaw
- ❑ Tooth Spacing - Excessive

Other: _____

MEDICATIONS CURRENTLY BEING TAKEN

- Y ❑ N ❑ Antibiotics
- Y ❑ N ❑ Anticoagulants
- Y ❑ N ❑ Barbiturates
- Y ❑ N ❑ Blood thinners
- Y ❑ N ❑ Codeine
- Y ❑ N ❑ Cortisone
- Y ❑ N ❑ Diet pills
- Y ❑ N ❑ Heart medication
- Y ❑ N ❑ Insulin
- Y ❑ N ❑ Muscle relaxants
- Y ❑ N ❑ Nerve pills
- Y ❑ N ❑ Pain medication
- Y ❑ N ❑ Sleeping pills
- Y ❑ N ❑ Sulfa drugs
- Y ❑ N ❑ Tranquilizers

Other: _____

For Office Use: _____

_____

MEDICAL HISTORY

Y ☐ N ☐ Adenoids have been Removed
Y ☐ N ☐ Tonsils have been Removed
Y ☐ N ☐ Allergy to: ☐ Latex ☐ Metals ☐ Plastic
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune Disorders
Y ☐ N ☐ Bleeding of Gums
Y ☐ N ☐ Blood Pressure: ☐ HIGH ☐ LOW
Y ☐ N ☐ Blood Sugar: ☐ HIGH ☐ LOW
Y ☐ N ☐ Cancer
Y ☐ N ☐ Convulsions/Epilepsy ☐ Convulsions ☐ Epilepsy
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Endocrine Disorders (thyroid, adrenal, pituitary or other glands)
Y ☐ N ☐ Facial Pain
Y ☐ N ☐ Headaches
Y ☐ N ☐ Hearing Impairment
Y ☐ N ☐ Heart: ☐ Disorder ☐ Heart Disorder and Murmur ☐ Murmur
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Injury to: ☐ Face ☐ Head ☐ Mouth ☐ Neck ☐ Teeth
Y ☐ N ☐ Jaw Pain
Y ☐ N ☐ Kidney Problems
Y ☐ N ☐ Muscle Aches
Y ☐ N ☐ Neck Pain
Y ☐ N ☐ Prior Orthodontic Treatment
Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ Ringing of the Ears
Y ☐ N ☐ Shortness of Breath
Y ☐ N ☐ Sinus Problems
Y ☐ N ☐ Snoring
Y ☐ N ☐ Speech Difficulties
Y ☐ N ☐ Tendency for: ☐ Colds ☐ Ear Infections ☐ Sore Throats
Y ☐ N ☐ Tuberculosis

Other: _____

For Office Use: _____

_____

_____

_____

TENDENCIES

Clenching/Grinding Teeth: Y ☐ N ☐ Frequent Y ☐ N ☐ Occasional

Lip Biting: Y ☐ N ☐ Frequent Y ☐ N ☐ Occasional

Y ☐ N ☐ Mouth Breather Habitual

Y ☐ N ☐ Nail Biter - Frequent

Thumb Sucking: Y ☐ N ☐ Current Y ☐ N ☐ Prior

Finger Sucking: Y ☐ N ☐ Current Y ☐ N ☐ Prior

Other: _____

For Office Use: _____

_____

_____

_____

OPERATIONS / HOSPITAL STAYS:

_____

_____

AUTHORIZATION

The undersigned affirm that the information given in this questionnaire is true and accurate to the best of my/our knowledge. I authorize the dental staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company for legal documentation.

I accept full responsibility for all charges for treatment to the patient regardless of insurance coverage.

Signature _____

Date ____/____/____

Relationship

☐ Patient ☐ Parent

☐ Guardian

☐ Other:_____