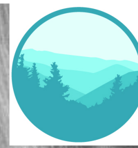

(For Patients Over Age 18)

Today's Date ___________________________________

Patient Name ___________________________________ Prefer to be called _________________________ Sex ________

Address ____

City, State, Zip____

Home Phone____________________________________ Email ______________________________________

Occupation____________________________________ Employed By _________________________________

Spouse's Name _________________________________ Work Phone __________________________________

Occupation____________________________________ Employed By _________________________________

Who may we contact in case of emergency? _______________________________________ Phone _______________

Family Dentist _________________________________ Family Physician _____________________________

In your opinion, what is your orthodontic problem? ____

____

Who may we thank for recommending you for your appointment?_____________________________________

Person responsible for account ____

Social Security # ______________________________ Birthdate______________________ Age________ Sex

Address ____

City, State, Zip____

Do you have orthodontic insurance coverage? No Yes, Company _______________________________

Group Number _________________________________ Phone/Contact ______________________________

Secondary Insurance Coverage ____

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HEALTH QUESTIONNAIRE

Today's Date ____________

Patient Name____________________________________ Birthdate _______________

Date of last dental visit or check-up ___________

Have you ever had the following dental treatment?

Orthodontics, Date ___________ , by Dr.___________
Periodontal treatment (gum treatment)
Mouthguard or splint therapy for jaw joint problems
Jaw surgery to change your bite or to correct jaw joint

Do you have or have you had any of the following oral conditions?

Clenching or grinding	Bleeding gums	Sensitive Teeth
Jaw joint sounds or pain	Bad Breath	Poorly functioning teeth
Jaw gets stuck open or closed	Food wedging between teeth	Swelling or lumps in the mouth
Pain in jaw or face	Injury or blow to the chin or jaw	Mouth Breathing
Pain when opening or closing mouth	Dry Mouth	Oral habits (thumb sucking, etc)
Pain around ear	Discolored teeth	Tobacco use

Do you have or have you had any of the following medical conditions?

Rheumatic Fever	Congenital heart lesions / murmur	Osteoporosis
Diabetes	Anemia	Asthma
Sleep Apnea	Kidney problems	Tuberculosis
Arthritis (any type)	Heart condition	Severe Headaches
Liver disease	High blood pressure	Dizziness or Fainting
Hepatitis type ______	Low blood pressure	Convulsions or seizure
Yellow jaundice	Ear problems	Sinus problems
Chronic Pain Disorders	Eye problems	Swallowing problems
Easy bruising	HIV positive	Speech problems

Are you currently under a physician's care? If yes, describe ___________________________	yes	no
Has patient ever been hospitalized or had any serious illness? If yes, describe ________________	yes	no
Does the patient have any drug allergies? If yes, list medications ____________________________	yes	no
Is the patient allergic to latex?	yes	no
Is the patient taking any medication? If yes, list medications ____________________________	yes	no
Have you ever taken Bisphosphonates to treat osteoporosis or other bone related diseases	yes	no
Female patients – could patient possibly be pregnant at the present time?	yes	no

Patient signature ______________________________ **Date**_______________

Notes:

____

____

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