

# Welcome

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Please take a few minutes to fill out the questionnaire so we can best serve your needs.  
Thank you for your attention as we desire to know you better.

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Last First Middle Initial  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Social Security Number or Insurance Card ID # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
Patient's email \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
School or Employer Firm Name \_\_\_\_\_ School Grade, Major, or Occupation \_\_\_\_\_  
Patient's Favorite Sports or Hobbies \_\_\_\_\_  
How did you hear about us? From Dr. \_\_\_\_\_ From my relative/friend \_\_\_\_\_  
From my insurance company \_\_\_\_\_ Other \_\_\_\_\_

If patient is a minor (under age 18), then complete parent's information below:

I am the patient's (circle one)... Mother Father Legal Guardian

**Mother's (or Legal Guardian's) Name** \_\_\_\_\_

Work Phone( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Mother's (or Legal Guardian's) email \_\_\_\_\_

Employer Firm Name \_\_\_\_\_ Occupation and Title \_\_\_\_\_

**Father's Name** \_\_\_\_\_

Work Phone( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Father's email \_\_\_\_\_

Employer Firm Name \_\_\_\_\_ Occupation and Title \_\_\_\_\_

Patient resembles (circle one) Mother Father Is adopted

Names and ages of siblings \_\_\_\_\_

Patient's Parents are (circle one) Married Widowed Separated Divorced

## Primary Orthodontic Insurance (if any)

Insurance Company Name \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date of birth \_\_\_\_\_

SS Number or Insurance ID# \_\_\_\_\_

## Secondary Orthodontic Insurance (if any)

Insurance Company Name \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date of birth \_\_\_\_\_

SS Number or Insurance ID# \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

If deemed necessary, I authorize the taking of study models, x-rays, photographs, or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's orthodontic needs.

If there are any changes in the information on these forms, I understand that it is my responsibility to update this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Medical History

Physician's or Medical Office Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you been a patient in a hospital? Yes / No  
 If yes, describe \_\_\_\_\_  
 Are you currently under medical care? Yes / No  
 If yes, describe \_\_\_\_\_  
 Are you taking any medications now? Yes / No  
 If yes, describe \_\_\_\_\_  
 Have you ever had a serious illness or operation? Yes / No  
 If yes, describe \_\_\_\_\_  
 Have you ever taken Phen-Fen or Redux? Yes / No  
 Are you allergic to any medicine? Yes / No  
 If yes, describe \_\_\_\_\_  
 Are you pregnant or think you may be? Yes / No  
 Are you taking oral contraceptives? Yes / No

Do you have any of the following conditions?

Heart Trouble	Yes / No	Kidney Problems	Yes / No	Seizures/Fainting Spells	Yes / No
Heart Attack	Yes / No	Hepatitis	Yes / No	Epilepsy	Yes / No
Coronary Insufficiency	Yes / No	Jaundice	Yes / No	Cerebral Palsy	Yes / No
Coronary Occlusion	Yes / No	Liver Disease	Yes / No	Psychiatric Treatment	Yes / No
High Blood Pressure	Yes / No	Excessive Bleeding	Yes / No	Venereal Disease	Yes / No
Arteriosclerosis	Yes / No	Tuberculosis	Yes / No	AIDS/HIV	Yes / No
Stroke	Yes / No	Lung Problems	Yes / No	Hives/Rashes	Yes / No
Mitral Valve Prolapse	Yes / No	Persistent Cough	Yes / No	Thyroid Disease	Yes / No
Heart Murmur	Yes / No	Emphysema	Yes / No	Nervous Disorder	Yes / No
Rheumatic Fever/	Yes / No	Sinus Problems	Yes / No	ADD/ADHD	Yes / No
Rheumatic Heart Disease	Yes / No	Stomach Ulcers	Yes / No	Mental Disability	Yes / No
Sickle Cell Disease	Yes / No	Diabetes	Yes / No	Hearing Disability	Yes / No
Bleeding Disorder	Yes / No	Inflammatory Rheumatism	Yes / No	Developmental Disability	Yes / No
Anemia	Yes / No	Arthritis	Yes / No	Cleft Lip/Palate	Yes / No
Congenital Heart Disease	Yes / No			Premature Birth	Yes / No
Penicillin/Amoxicillin Allergy	Yes / No			How many weeks? _____	
Allergic to _____	Yes / No				

Do you have any conditions not mentioned above? If yes, what: \_\_\_\_\_

# Dental History

Reason for Today's Visit and What concerns do you have about your teeth? \_\_\_\_\_

When was your most recent visit to the general dentist? \_\_\_\_\_

General Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Have there been any injuries to the face, mouth or teeth? Yes / No

If yes, describe: \_\_\_\_\_

Have you ever sucked a thumb or fingers? Yes / No

If yes, until what age? \_\_\_\_\_

Do you have any speech problems? Yes / No

If yes, describe: \_\_\_\_\_

Are you a mouth breather while awake or asleep? Yes / No

Do you bite your nails, lip or tongue? Yes / No

Do you grind your teeth at night? Yes / No

Has either parent had orthodontic treatment? Yes / No

Have you been informed of any missing or extra permanent teeth? Yes / No

Has an orthodontist been consulted previously? Yes / No

If yes, who and when? \_\_\_\_\_

Have we treated any other family members? Yes / No

If yes, who? \_\_\_\_\_

I have answered all questions truthfully and to the best of my knowledge.

\_\_\_\_\_  
Name of patient (please print) Signature Date

\_\_\_\_\_  
Name of parent/legal guardian (please print) Signature Date

\_\_\_\_\_  
Review Medical History/Comments Dentist Signature Date

*For recall patients only: Medical History Update*

*I have reviewed the above medical history and there have been no changes since the first date I signed above.*

\_\_\_\_\_  
Signature Date Signature of Dentist Date

*For recall patients only: Medical History Update*

*I have reviewed the above medical history and there have been no changes since the first date I signed above.*

\_\_\_\_\_  
Signature Date Signature of Dentist Date