BZ Orthodontics
Health Questionnaire and Patient Information

Patient Information

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐ Rev.☐ Other_____

First Name_____ Middle_____ Last Name_____

Nick Name_____ Birth Date_____ Age_____

Home Phone_____ Cell Phone_____

Work Phone_____ Cell Phone Carrier_____

Address_____

City, State, Zip_____ E-mail_____

Sex Male☐ Female☐ Patient Social Security_____ _____ _____

Father's Name (if applicable)_____ Cell phone_____

Mother's Name (if applicable)_____ Cell phone_____

Dentist's Name_____ Dentist's Address_____

Did your dentist refer you to our office?_____ Date of last cleaning_____

Who may we thank for referring you to our practice? _____

How did you hear about our practice? _____

Physician's Name and Address _____

List immediate family members that are currently or have been in our practice_____

_____

Responsible Party

Mr. & Mrs. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other_____

Name_____

Home Phone_____ Cell Phone_____

Work Phone_____ Resp. Social Security_____ _____ _____

Address_____

City, State, Zip_____

Relationship to Patient_____ E-mail_____

Dental Insurance Information

Insurance Company (***show card for duplication***)_____

Name of Policy Holder_____ SSN_____ _____ _____

Relationship of Policy Holder to Patient_____

Address of Policy Holder_____

Phone Number of Policy Holder_____

Group Number_____ ID Number_____

Birth Date of Policy Holder_____

Employer Name and Address_____

_____ Phone_____

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What are the patient's or parent's main concerns regarding the jaws and teeth?

Crowding	☐ Yes ☐ No	Mouth too small	☐ Yes ☐ No
Overbite	☐ Yes ☐ No	Clicking jaw joint	☐ Yes ☐ No
Buck teeth	☐ Yes ☐ No	Irregularly shaped teeth	☐ Yes ☐ No
Receded jaw	☐ Yes ☐ No	Protrusion of teeth	☐ Yes ☐ No
Prominent jaw	☐ Yes ☐ No	Ringing/stuffiness of ears	☐ Yes ☐ No
Gummy smile	☐ Yes ☐ No	Headaches/facial pain	☐ Yes ☐ No
Spaces ☐ Yes	☐ No	Neck pain	☐ Yes ☐ No
Gum disease/recession	☐ Yes ☐ No	Jaw pain	☐ Yes ☐ No
Missing teeth	☐ Yes ☐ No	Irregular facial proportions	☐ Yes ☐ No
Jaw dysfunction	☐ Yes ☐ No	Other_____	

The following are also of interest to the orthodontist:

Does the patient: Snore when sleeping? ☐ Yes ☐ No

	Breathe through the mouth?	☐ Yes	☐ No		
	Drink more than 1 glass of milk per day?	☐ Yes	☐ No		
	Have frequent colds?	☐ Yes	☐ No		
	Have frequent sore throats or tonsillitis	☐ Yes	☐ No		
	Have difficulty swallowing?	☐ Yes	☐ No		
	Have difficulty chewing?	☐ Yes	☐ No		
	Have pain/clicking in the jaw joint?	☐ Yes	☐ No		
	Have speech problems?	☐ Yes	☐ No		
Habits:	Thumb/finger sucking?	☐ Yes	☐ No	(Previously ☐	Presently ☐)
	Lip biting or sucking?	☐ Yes	☐ No	(Previously ☐	Presently ☐)
	Grinding of teeth?	☐ Yes	☐ No	(Previously ☐	Presently ☐)
	Clenching?	☐ Yes	☐ No	(Previously ☐	Presently ☐)
	Tongue thrusting?	☐ Yes	☐ No	(Previously ☐	Presently ☐)
	Smoking?	☐ Yes	☐ No	(Previously ☐	Presently ☐)
	Other habits?	_____			

Patient's attitude toward general dental health and orthodontics:

Dental check-ups?

☐ Every 6 months ☐ Every 12 months ☐ As necessary ☐ Never

Interest in orthodontic treatment?

☐ Wants treatment ☐ Only if necessary ☐ Unwilling but agrees ☐ Uncooperative

Orthodontic consultation prompted by?

☐ Parent/patient ☐ Dentist ☐ Physician ☐ Other

Previous orthodontic consultation or treatment?

☐ Yes ☐ No

Any unusual dental experiences?

☐ Yes ☐ No If yes, please specify_____

Medical/Dental History

Present Health

Physical health: ☐ Good ☐ Fair ☐ Poor

Emotional health: ☐ Good ☐ Fair ☐ Poor

If a child, has patient reached puberty? ☐ Yes ☐ No

Is child adopted? ☐ Yes ☐ No

Has the patient ever had any of the following conditions?

ADD/ADHD	☐ Yes	☐ No	☐ Current	Hearing disorder	☐ Yes	☐ No	☐ Current
AIDS/HIV	☐ Yes	☐ No	☐ Current	Kidney disease	☐ Yes	☐ No	☐ Current
Allergies (seasonal)	☐ Yes	☐ No	☐ Current	Joint replacement	☐ Yes	☐ No	☐ Current
Arteriosclerosis	☐ Yes	☐ No	☐ Current	Osteoarthritis	☐ Yes	☐ No	☐ Current
Asthma	☐ Yes	☐ No	☐ Current	Pregnant	☐ Yes	☐ No	☐ Current
Autoimmune disorder	☐ Yes	☐ No	☐ Current	Prosthesis	☐ Yes	☐ No	☐ Current
Blood disease	☐ Yes	☐ No	☐ Current	Rheumatic fever	☐ Yes	☐ No	☐ Current
High blood pressure	☐ Yes	☐ No	☐ Current	Rheumatoid arthritis	☐ Yes	☐ No	☐ Current
Low blood pressure	☐ Yes	☐ No	☐ Current	Ringing of ears	☐ Yes	☐ No	☐ Current
Bone disorders	☐ Yes	☐ No	☐ Current	Sensory issues	☐ Yes	☐ No	☐ Current
Cancer	☐ Yes	☐ No	☐ Current	Sleep apnea	☐ Yes	☐ No	☐ Current
Diabetes, Type I	☐ Yes	☐ No	☐ Current	If yes, CPAP device	☐ Yes	☐ No	☐ Current
Diabetes, Type II	☐ Yes	☐ No	☐ Current	Sleep disturbance	☐ Yes	☐ No	☐ Current
Dizziness	☐ Yes	☐ No	☐ Current	Visual disorders	☐ Yes	☐ No	☐ Current
Down Syndrome	☐ Yes	☐ No	☐ Current	Trauma to head, face, or jaws			
Epilepsy	☐ Yes	☐ No	☐ Current		☐ Yes	☐ No	☐ Current
Endocrine problems	☐ Yes	☐ No	☐ Current	Specify_____			
Emotional problems	☐ Yes	☐ No	☐ Current	Autism	☐ Yes	☐ No	☐ Current
Hepatitis	☐ Yes	☐ No	☐ Current	Specify_____			
Heart disease	☐ Yes	☐ No	☐ Current	Other_____			
Heart murmur	☐ Yes	☐ No	☐ Current				
Herpes/Cold Sores	☐ Yes	☐ No	☐ Current				

Allergies (if yes, please specify):

Antibiotics ☐ Yes ☐ No _____

Food dye ☐ Yes ☐ No _____

Foods ☐ Yes ☐ No _____

Latex ☐ Yes ☐ No _____

Nickel ☐ Yes ☐ No _____

Pain medication ☐ Yes ☐ No _____

Seasonal ☐ Yes ☐ No _____

Other _____

EpiPen is needed ☐ Yes ☐ No

EpiPen is carried ☐ Yes ☐ No

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Medications currently being taken by the patient:

Antibiotics	☐ Yes ☐ No	Muscle relaxants	☐ Yes ☐ No
Birth control pills	☐ Yes ☐ No	Insulin	☐ Yes ☐ No
Diet pills	☐ Yes ☐ No	Thyroid medication	☐ Yes ☐ No
Diuretics	☐ Yes ☐ No	Vitamins	☐ Yes ☐ No
Heart medication	☐ Yes ☐ No	Pain medication	☐ Yes ☐ No
Sleeping aids	☐ Yes ☐ No	Osteoporosis medication	☐ Yes ☐ No

Other_____

If yes, please specify name, dosage and frequency_____

_____

Premedication

Does the patient require premedication prior to dental procedures? ☐ Yes ☐ No

If so, who prescribes this medication?_____

Name of medication_____

Any medical or dental problems not covered previously in this questionnaire?

☐ Yes ☐ No If yes, please specify_____

_____

_____

_____

_____ _____

Date **Signature of Patient (Parent, if patient is a minor)**

_____ _____ DDS

Date **Signature of Orthodontist**