



Health Questionnaire & Patient Information

PATIENT INFORMATION

Mr. Mrs. Ms. Miss Rev. Dr. Other: _____

Patient's Name: _____ Nickname: _____
First Middle Last

Birth Date: _____ Age: _____ Home Phone: _____ Cell Phone: _____

Cell Phone Carrier: _____ Work Phone: _____

Address: _____
Street City State Zip Code

Email: _____ 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? Y/N 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. Ms. Miss Rev. Dr. Other: _____

Name: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Resp. Social Security: _____

Address: _____
Street City State Zip Code

Relationship to Patient: _____ Email: _____

DENTAL INSURANCE INFORMATION

Insurance Company (show card for duplication): _____

Name of Policy Holder: _____ SSN: _____

Relationship of Policy Holder to Patient: _____

Address of Policy Holder: _____
Street City State Zip Code

Number of Policy Holder: _____

Group Number: _____ ID Number: _____

Birth Date of Policy Holder: _____ Employer Name & Address: _____

Phone: _____



WHAT ARE THE PATIENT'S OR PARENT'S MAIN CONCERNS REGARDING THE JAWS AND TEETH?

- Crowding
- Overbite
- Buck Teeth
- Receded Jaw
- Prominent Jaw
- Gummy Smile
- Spaces
- Gum Disease/Recession
- Missing Teeth
- Jaw Dysfunction
- Mouth Too Small
- Clicking Jaw Joint
- Irregularly Shaped Teeth
- Protrusion of Teeth
- Ringing/Stiffness of Ears
- Headaches/Facial Pain
- Neck Pain
- Jaw Pain
- Irregular Facial Proportions
- Other _____

THE FOLLOWING ARE ALSO OF INTEREST TO THE ORTHODONTIST:

DOES THE PATIENT HAVE: YES NO

- 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: YES NO PREVIOUSLY PRESENTLY

- 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? _____ YES NO PREVIOUSLY PRESENTLY

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

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
- AIDS/HIV Yes No Current
- Allergies (Seasonal) Yes No Current
- Arteriosclerosis Yes No Current
- Asthma Yes No Current
- Autoimmune Disorder Yes No Current
- Blood Disease Yes No Current
- High Blood Pressure Yes No Current
- Low Blood Pressure Yes No Current
- Bone Disorders Yes No Current
- Cancer Yes No Current
- Type I Diabetes Yes No Current
- Type II Diabetes Yes No Current
- Dizziness Yes No Current
- Down Syndrome Yes No Current
- Endocrine Problems Yes No Current
- Emotional Problems Yes No Current
- Hepatitis Yes No Current
- Heart Disease Yes No Current
- Heart Murmur Yes No Current
- Herpes/Cold Sores Yes No Current

- Hearing Disorder Yes No Current
- Kidney Disease Yes No Current
- Joint Replacement Yes No Current
- Osteoarthritis Yes No Current
- Pregnant Yes No Current
- Prosthesis Yes No Current
- Rheumatic Fever Yes No Current
- Rheumatoid Arthritis Yes No Current
- Ringing of Ears Yes No Current
- Sensory Issues Yes No Current
- Sleep Apnea Yes No Current
- If Yes, CPAP Device* Yes No Current
- Sleep Disturbance Yes No Current
- Visual Disorders Yes No Current
- Trauma To Head, Face, Or Jaws Yes No Current
- Specify* _____
- Autism Yes No Current
- Specify* _____
- Other _____

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 _____
- EpiPen Is Needed Yes No _____
- EpiPen Is Carried Yes No _____
- Other _____



MEDICATIONS CURRENTLY BEING TAKEN BY THE PATIENT:

- | | | | | | |
|---------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| Antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Muscle Relaxants | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Birth Control Pills | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diet Pills | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diuretics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vitamins | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleeping Aids | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)*

Date

Signature of Orthodontist