

-Orthodontic Questionnaire-

Patient Information	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	
Name: _____	
Address _____	
City/State/State _____	
How long at current address? _____	
Phone# _____ SS# _____	
Birth Date _____ Age _____ Male Female	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Dependent	

Employment Information
Employer _____
Work Phone _____
Occupation _____
How long at Current Job? _____

Responsible Party (If other than patient)	
Relationship to patient _____	Phone # _____ Cell # _____
Name: _____	Birth Date _____ Age _____
Address _____	SS# _____ Male Female
City/State/State _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed
How long at current address? _____	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced

Insurance	
Insurance Company _____	Insured's Employer _____
Address _____	Insured's Name _____
City/State/State _____	Relationship to Patient _____
Phone # _____	Insured's SS# or Membership # _____
How long at current address? _____	Group / Policy Number _____

Whom may we thank for referring you to our office? _____

If it was from Internet what words did you use to search for us (example: Southfield dentist) _____

Name of nearest relative not living with you _____

Phone# _____

Family Physician _____

Please list all other health care practitioners seen in the last nine months

Practitioner	Specialty	Approximate date of treatment

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Reason for visit

- | | | |
|---|--|---|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Mismatched Bite | <input type="checkbox"/> "Buck" or Protruding Teeth |
| <input type="checkbox"/> Missing Tooth | <input type="checkbox"/> Clicking of Jaw Joint | <input type="checkbox"/> Missing Teeth |
| <input type="checkbox"/> Crowded Teeth | <input type="checkbox"/> Neck Pain – Frequent | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Orthodontic Second Opinion | <input type="checkbox"/> Gum Disease or Recession | <input type="checkbox"/> Overbite |
| <input type="checkbox"/> Head Pain | <input type="checkbox"/> Overly Small Mouth | <input type="checkbox"/> Irregular Facial Proportions |
| <input type="checkbox"/> Prominent Jaw | <input type="checkbox"/> Irregularly Shaped Teeth | <input type="checkbox"/> Receded Jaw |
| <input type="checkbox"/> Jaw Dysfunction | <input type="checkbox"/> Tooth Spacing – Excessive | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Other _____ | | |

Medications Currently Being Taken

- | | | | |
|--|------------------|--|------------------|
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Antibiotics | Yes <input type="checkbox"/> No <input type="checkbox"/> | Insulin |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Anticoagulants | Yes <input type="checkbox"/> No <input type="checkbox"/> | Muscle Relaxants |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Barbiturates | Yes <input type="checkbox"/> No <input type="checkbox"/> | Nerve Pills |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Thinners | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pain Medication |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Codeine | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sleeping Pills |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Cortisone | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sulfa Drugs |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Diet Pills | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tranquilizers |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Medication | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other: _____ |

Medical History

- | | | | |
|--|--|--|---------------------|
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Adenoids have been removed | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Tonsils have been removed | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Allergy to: <input type="checkbox"/> Latex <input type="checkbox"/> Metals <input type="checkbox"/> Plastic | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Asthma | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Autoimmune Disorders | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Bleeding of Gums | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Cancer | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Convulsions/Epilepsy <input type="checkbox"/> Convulsions <input type="checkbox"/> Epilepsy | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Diabetes | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Endocrine Disorders (thyroid, adrenal, pituitary or other glands) | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Facial Pain | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Headaches | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Hearing Impairment | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart <input type="checkbox"/> Disorder <input type="checkbox"/> Heart Disorder and Murmur <input type="checkbox"/> Murmur | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemophilia | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Injury to: <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Teeth | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaw Pain | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | Shortness of Breath |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Muscle Aches | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Problems |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Neck Pain | Yes <input type="checkbox"/> No <input type="checkbox"/> | Snoring |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Prior Ortho Treatment | Yes <input type="checkbox"/> No <input type="checkbox"/> | Speech Difficulties |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Rheumatic Fever | Yes <input type="checkbox"/> No <input type="checkbox"/> | ringing in the Ears |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Tendency for: <input type="checkbox"/> Colds <input type="checkbox"/> Ear Infections <input type="checkbox"/> Sore Throats | | |

Other: _____



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Tendencies

- | | | | | | | |
|--------------------------|-----|--------------------------|----|--------------------------|----------|------------|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Clenching/Grinding Teeth | Frequent | Occasional |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Lip Biting | | |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Mouth Breather Habitual | | |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Nail Biter - Frequent | | |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Thumb Sucking | Current | Prior |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Finger Sucking | Current | Prior |

Operations / Hospital Stays

AUTHORIZATION

I the undersigned affirm that the information given in this questionnaire is true and accurate to the best of my knowledge. I authorize 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 or for legal documentation.

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

Patient Signature _____ Date _____

Relationship Parent Patient Guardian Other

For Office Use