Advanced Orthodontics

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GET ACQUAINTED QUESTIONNAIRE

ADULT

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's full name________________________Date of Birth___________Age_________Phone___________
Address_____________________________City____________________State_______Zip________________
Email Address__________________________________Cell Phone___________________________________
Family Dentist____________________City_________________Phone_____________Last Visit:___________
Family Physician________________________City__________________________Phone__________________
Name patient likes to be called_________________________________
Sports, Hobbies, etc.____
Single__________Married___________Separated__________Divorced__________Widowed__________
Children (names/ages)____
Major reason for seeking orthodontic treatment____
How did you hear about our office?____

DENTAL HISTORY

	No	Unsure	Yes	
Have there been any injuries to the face, mouth or teeth?..........	☐	☐	☐	notes:__________________
Are you aware of any missing or extra permanent teeth?...........	☐	☐	☐	notes:__________________
Do you have any speech problems or concerns?.......................	☐	☐	☐	notes:__________________
Are you especially apprehensive toward dental visits?...............	☐	☐	☐	notes:__________________
Do you:				
• clench or grind your teeth?	☐	☐	☐	notes:__________________
• brush your teeth conscientiously?....................................	☐	☐	☐	notes:__________________
Do you have:				
• a history of periodontal (gum) problems?	☐	☐	☐	notes:__________________
• a problem with frequent cold/canker sores?	☐	☐	☐	notes:__________________
• any difficulty opening your mouth?	☐	☐	☐	notes:__________________
• any clicking or discomfort in jaw joints near ears?...........	☐	☐	☐	notes:__________________
• headaches or neckaches regularly?	☐	☐	☐	notes:__________________
• pain in the jaw joints while eating?..................................	☐	☐	☐	notes:__________________
• any congenital abnormalities? (cleft palate, etc.).............	☐	☐	☐	notes:__________________

ATTITUDE TOWARD TREATMENT

Are you aware of spaced, crooked or protruding teeth?................ ☐ No.... ☐ Yes Concerned?.....☐ No... ☐ Yes
Do you feel that it is becoming .... ☐ Better......... ☐ Worse............ ☐ Staying the Same
What would you most like to have orthodontic treatment accomplish? ____________________________________
Are you aware that some appointments will infringe upon school/work time?................ ☐ No........ ☐ Yes
Have you had any previous orthodontic examinations?........... ☐ No....... ☐ Yes. ....Doctor:___________Date:________
Have you had any previous orthodontic treatment?_________Describe:______________________________________

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Please check no or yes to the following and indicate the year:

	No	Yes	Years		No	Yes	Years
Attention Deficit Disorder	____	____	____	Hay Fever	____	____	____
Allergies	____	____	____	Healing Disorder	____	____	____
Anemia or Bleeding Problems	____	____	____	Headaches	____	____	____
Arthritis	____	____	____	Hearing Disorder	____	____	____
Asthma	____	____	____	Heart Disorders (murmur, etc.)	____	____	____
Behavioral Problems	____	____	____	Hepatitis or Liver Disorders	____	____	____
Bone or Joint Disorder	____	____	____	HIV Positive	____	____	____
Breathing or Nasal Disorder	____	____	____	Kidney or Bladder Condition	____	____	____
Diabetes	____	____	____	Mononucleosis	____	____	____
Earaches	____	____	____	Nervous Disorders	____	____	____
Epilepsy or Convulsions	____	____	____	Psychiatric Treatment	____	____	____
Fainting or Dizziness	____	____	____	Psychological Disorder	____	____	____
Gagging or Nausea Problems	____	____	____	Rheumatic Fever	____	____	____
Growth or Endocrine Condition	____	____	____	Sexually Transmitted Infection	____	____	____

General health: Good________Fair________Poor_________Birth Defects______________________________

Presently under medical care for____

Drugs or medication being taken now (drug and dose)____

Allergic to any medication____

Do you require antibiotic premedication prior to dental appointments?......... ☐ No.... ☐ Yes

Are you a mouth breather?............................ ☐ No...... ☐ Yes.............. ☐ While asleep........... ☐ While awake

Have tonsils and adenoids been removed?.... ☐ No...... ☐ Yes. ....At what age?_____________

Do you snore at night?.................................. ☐ No..... ☐ Yes

RESPONSIBLE PARTY INFORMATION

Name____

Residence ____

Mailing Address ____ Zip

How long at this address_______________Home Phone___________________Work Phone ______ Zip

Social Security #__________________Birthdate___________________Relationship to Patient_____________

Employer_________________________Occupation______________________No. Years Employed __________

Spouse's Name____Relationship to Patient ____________

Spouse's Address ____

Employer_________________________Occupation______________________No. Years Employed ________

Social Security #__________________Birthdate_______________________Work Phone ______________

Emergency contact person ____

Name Home Phone Work Phone

ORTHODONTIC INSURANCE INFORMATION

Insurance Company________________________Group No.______________________Local No. ___________

Insurance Co. Address ____

Insured's Name____Insured's Soc. Sec. # ________________

Insured's Employer ____

Do you have dual coverage? ☐ No ☐ Yes If Yes:

Insurance Company___________________________Group No.___________________Local No. ___________

Insurance Co. Address ____

Insured's Name____Insured's Soc. Sec. # ________________

Insured's Employer ____

I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian____Date________________

I give permission for x-rays and photographs to be used for research/educational purposes ________________

Initials