

**PATIENT INFORMATION  
ADULT**

DATE \_\_\_\_\_

NAME(First, Middle, Last): \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

Employer \_\_\_\_\_

Social Security Number \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE \_\_\_\_\_

DENTIST NAME & ADDRESS \_\_\_\_\_

IMMEDIATE ORTHODONTIC CONCERN OR PROBLEM \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (if different than above):**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**PRIMARY DENTAL INSURANCE COVERAGE**

Insured Name: \_\_\_\_\_

Pt relation to Insured: Self/Spouse/Child/Other \_\_\_\_\_

Address (If different than above) \_\_\_\_\_

S/S No. \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group No: \_\_\_\_\_ ID No: \_\_\_\_\_

Address of Ins. Co: \_\_\_\_\_

**EMERGENCY INFORMATION:**

Name of nearest relative not living with you \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**Please continue on the reverse side of page...OVER**

# HEALTH QUESTIONNAIRE

NAME & ADDRESS OF PHYSICIAN \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING: INDICATE WITH AN "X"

- |   |   |
|---|---|
| <input type="checkbox"/> TEETH SENSITIVE TO COLD, HEAT,<br>SWEETS OR PRESSURE | <input type="checkbox"/> ORTHODONTIC TREATMENT  |
| <input type="checkbox"/> BLEEDING GUMS HOW LONG _____                         | <input type="checkbox"/> MOUTH BREATHING  |
| <input type="checkbox"/> FOOD IMPACTION                                       | <input type="checkbox"/> ORAL HABITS, I.E., FINGERNAIL BITING,<br>CHEEK BITING, ETC.  |
| <input type="checkbox"/> CLENCHING OR GRINDING                                | <input type="checkbox"/> CIGARETTES, PIPE OR CIGAR SMOKING                            |
| <input type="checkbox"/> BURNING OF TONGUE                                    | <input type="checkbox"/> FREQUENT BRUSHING  |
| <input type="checkbox"/> SWELLING OR LUMPS IN MOUTH                           | <input type="checkbox"/> DENTAL FLOSS   |
| <input type="checkbox"/> PAIN AROUND EAR                                      | <input type="checkbox"/> WATER JET DEVICE   |
| <input type="checkbox"/> UNUSUAL SOUNDS IN EAR WHEN EATING                    | <input type="checkbox"/> FLUORIDE SUPPLEMENTS   |
| <input type="checkbox"/> BAD BREATH   | <input type="checkbox"/> THUMBSUCKING   |
| <input type="checkbox"/> UNPLEASANT TASTE                                     | <input type="checkbox"/> TONGUE THRUST  |
| <input type="checkbox"/> UNFAVORABLE DENTAL EXPERIENCE                        | <input type="checkbox"/> DO YOU PLAY A MUSICAL INSTRUMENT?<br>IF SO, WHAT KIND? _____ |
| <input type="checkbox"/> COMPLICATIONS FROM EXTRACTIONS                       |   |
| <input type="checkbox"/> PERIODONTAL TREATMENT                                |   |

**DO YOU REQUIRE PRE-MEDICATION FOR DENTAL PROCEDURES: YES NO UNSURE**

**HAVE YOU EVER TAKEN FEN-PHEN OR REDUX: YES NO**

## MEDICAL HISTORY

- |   |   |
|---|---|
| <input type="checkbox"/> ALLERGIES TO DRUGS<br>IF SO, WHAT _____      | <input type="checkbox"/> KIDNEY PROBLEMS                          |
| <input type="checkbox"/> ALLERGIES TO ANESTHETICS                     | <input type="checkbox"/> LIVER PROBLEMS OR HEPATITIS              |
| <input type="checkbox"/> ANY HEART AILMENTS                           | <input type="checkbox"/> PSYCHIATRIC CARE / EMOTIONAL PROBLEMS    |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                          | <input type="checkbox"/> SINUS PROBLEMS                           |
| <input type="checkbox"/> SEIZURES                                     | <input type="checkbox"/> RHEUMATIC FEVER                          |
| <input type="checkbox"/> NEUROLOGICAL PROBLEMS                        | <input type="checkbox"/> MITRAL VALVE PROLAPSE                    |
| <input type="checkbox"/> LEARNING DISABILITIES                        | <input type="checkbox"/> JOINT REPLACEMENT                        |
| <input type="checkbox"/> RADIATION TREATMENTS                         | <input type="checkbox"/> IMMUNE SYSTEM DISORDERS (AIDS, HIV, ARC) |
| <input type="checkbox"/> MALIGNANCIES                                 | <input type="checkbox"/> STROKE                                   |
| <input type="checkbox"/> EXCESSIVE BLEEDING FROM CUT<br>OR EXTRACTION | <input type="checkbox"/> EYE DISORDERS                            |
| <input type="checkbox"/> ANEMIA OR BLOOD PROBLEMS                     | <input type="checkbox"/> TONSILITIS                               |
| <input type="checkbox"/> THYROID                                      | <input type="checkbox"/> TUBERCULOSIS                             |
| <input type="checkbox"/> ARTHRITIS                                    | <input type="checkbox"/> ULCER OR COLITIS                         |
| <input type="checkbox"/> ASTHMA                                       | <input type="checkbox"/> PREGNANT (IF SO, WHAT MONTH? _____)      |
| <input type="checkbox"/> HAY FEVER OR ALLERGIES IN GENERAL            | <input type="checkbox"/> VENERAL DISEASE                          |
| <input type="checkbox"/> DIABETES                                     | <input type="checkbox"/> INJURIES TO MOUTH/JAW AREA               |
|   | <input type="checkbox"/> OTHER _____                              |

DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING ANY MEDICATIONS NOT MENTIONED ABOVE

\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF RESPONSIBLE PARTY** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_

**DATE:** \_\_\_\_\_