Practice Limited to Orthodontics for Children and Adults

**IN ORDER TO PERFORM A MORE COMPLETE SERVICE FOR OUR PATIENTS, WE ASK YOUR COOPERATION IN COMPLETING THIS QUESTIONNAIRE.**

## PATIENT INFORMATION

Patient Name ______________________________ M □ F □

Soc. Sec. # ____________ Nickname ______________ Birthdate ____________

Address ______________________________ Tel. # ____________

Street City/State Zip

E-Mail Address ______________________________ Cell # ____________

Do you wish to have E-mail appointment reminders? Yes □ No □

Do you wish to have Text Message appointment reminders? Yes □ No □

Dentist ______________ Address ______________________________

Street City/State Zip

Physician ______________ Address ______________________________

Street City/State Zip

Referred by ______________________________

School ______________ Grade ________ Sports ______________

Play a musical instrument? ____________ Hobbies ____________ Interests ____________

## RESPONSIBLE PARTY INFORMATION

Father's Name ______________________________ Soc. Sec. # ____________

Address ______________________________

How long at this address? ________If less than 3 years, previous address ______________How long? _____

E-Mail Address ______________________________ Cell # ____________

Do you wish to have E-mail appointment reminders? Yes □ No □

Do you wish to have Text Message appointment reminders? Yes □ No □

Occupation ______________________________ Business Tel. No. ____________

Business Name ______________________________

Mother's Name ______________________________ Soc. Sec. # ____________

Address ______________________________

How long at this address? ________If less than 3 years, previous address ______________How long? _____

E-Mail Address ______________________________ Cell # ____________

Do you wish to have E-mail appointment reminders? Yes □ No □

Do you wish to have Text Message appointment reminders? Yes □ No □

Occupation ______________________________ Business Tel. No. ____________

Business Name ______________________________

Person(s) Financially Responsible ______________________________ Relationship ____________

Insurance covering orthodontics ______________________________ Carrier ____________

## ORTHODONTIC INFORMATION

1. Reason for orthodontic consultation: ______________________________
2. Previous treatment - patient or others in immediate family:

Yes □ No □ If yes, who? ______________________________

With what results? _____Excellent _____ Good _____Poor

3. Have you had a previous orthodontic consultation?

Yes □ No □ If yes, with whom? ______________________________

4. What do you consider to be the main benefits of orthodontic correction?

_____Cosmetic _____ Functional _____Psychological/Emotional Other ______________________________

Which are factors in this instance? ______________________________

5. Is patient self-conscious of his/her teeth?

Yes □ No □ If yes, please explain ______________________________

6. Patient's attitude toward orthodontic treatment: _____ Enthusiastic _____Indifferent _____Resentful

7. Expected patient cooperation: _____Excellent _____ Good _____Fair _____Poor

8. Are both parents in favor of treatment?

Yes □ No □ ______________________________

9. Are parents aware that orthodontic appointments will infringe on school time?

Yes □ No □ ______________________________

## MEDICAL HISTORY

1. Patient size: _____Average _____Large _____Small

Height _____ Weight _____ Father's Ht. _____ Mother's Ht. _____ Adopted _____ Natural Child _____

2. Present state of health: _____Excellent _____ Good _____Fair _____Poor

3. Currently under physician's care:

Yes □ No □ Why? ______________________________

______________________________

4. Currently taking medication:

Yes □ No □ What? ______________________________

______________________________

5. Is there any **patient** history: (If you answer **yes** to any of the following questions, please explain to the right of the question.)

Yes □ No □ Facial accidents? ______________________________
Yes □ No □ Facial operations? ______________________________
Yes □ No □ Environmental allergies? ______________________________
Yes □ No □ Allergies to medication? ______________________________
Yes □ No □ Emotional disorders? ______________________________
Yes □ No □ Vision impairment? ______________________________
Yes □ No □ Hearing problems? ______________________________
Yes □ No □ Tonsillitis? ______________________________
Yes □ No □ Speech problems? ______________________________
Yes □ No □ Blood disorders? ______________________________
Yes □ No □ Immune System Disorders?______________________________
Yes □ No □ Birth defects? ______________________________
Yes □ No □ Asthma? ______________________________
Yes □ No □ Anemia? ______________________________
Yes □ No □ Diabetes? ______________________________
Yes □ No □ Hepatitis? ______________________________
Yes □ No □ Rheumatic Fever? ______________________________
Yes □ No □ Epilepsy? ______________________________
Yes □ No □ Heart Disease problems including murmurs? ______________________________
Yes □ No □ Liver or Kidney disease? ______________________________
Yes □ No □ TMJ (jaw joint problems)? ______________________________
Yes □ No □ Arthritis? ______________________________

6. Serious illness other than usual childhood disorders? ______________________________

______________________________

7. Has the patient ever been hospitalized?

   Yes □ No □ If yes, for what and the date: ______________________________

   ______________________________

8. Is the patient under psychological guidance?

   Yes □ No □ If yes, for what? ______________________________

   Mental development: _____ Above Average _____ Average _____ Below Average

## DENTAL HISTORY

1. When was patient's last visit to his/her general dentist? ______________________________
2. Has patient had: _____ Previous dental treatment? _____Regular dental check-ups? _____X-rays?

   _____Extractions? _____Impressions?
3. Has patient ever lost or chipped any teeth?

   Yes □ No □ If yes, explain the circumstances ______________________________
4. Eruption of teeth: _____Early _____Average _____Late _____Markedly delayed
5. Oral hygiene habits: _____Good _____Poor Intake of sweets: _____High _____Moderate _____Low
6. Has the patient ever received a blow to the teeth or jaws?

   Yes □ No □ If yes, please explain: ______________________________

   ______________________________
7. Indicate habits, past or present, relating to the mouth or face:

   Yes □ No □ Thumb □ Finger □ Object □ sucking? ______________________________
   Yes □ No □ Mouth breathing? ______________________________
   Yes □ No □ Lip biting? ______________________________
   Yes □ No □ Tongue thrust (reverse swallow)? ______________________________
   Yes □ No □ Chewing habits? ______________________________
   Yes □ No □ Nail biting? ______________________________
   Yes □ No □ Postural habits? ______________________________
   Yes □ No □ Sleeping habits (blanket sucking)? ______________________________
   Yes □ No □ Tooth grinding/clenching? ______________________________
   Yes □ No □ Poor speech habits? ______________________________
8. Is there any hereditary background (familial tendency) which might contribute to this orthodontic problem?

   ______________________________

   ______________________________

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting service.

Signed ______________________________ Date ______________________________
(Parent or Guardian)