



PATIENT QUESTIONNAIRE

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ Age \_\_\_\_\_ Years \_\_\_\_\_ Months SEX [ ] M [ ] F

ADDRESS: Street \_\_\_\_\_

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

TELEPHONE: Residence ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_

OCCUPATION/Grade in School: \_\_\_\_\_

PERSON RESPONSIBLE FOR FINANCIAL MATTERS:

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

Address: Street \_\_\_\_\_

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

Telephone: Residence ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? yes \_\_\_ no \_\_\_

Insurance Co. Name: \_\_\_\_\_ Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: ( ) \_\_\_\_\_ Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_ / \_\_\_ / \_\_\_ SS#: \_\_\_ - \_\_\_ - \_\_\_ Policy Owner's Employer \_\_\_\_\_

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? yes \_\_\_ no \_\_\_

Insurance Co. Name: \_\_\_\_\_ Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: ( ) \_\_\_\_\_ Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_ / \_\_\_ / \_\_\_ SS#: \_\_\_ - \_\_\_ - \_\_\_ Policy Owner's Employer \_\_\_\_\_

**1. FAMILY STATUS:**

Mother's Information: Mother \_\_\_ Step Mother \_\_\_ Guardian \_\_\_  
Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Home #: ( ) \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

Father's Information: Father \_\_\_ Step Father \_\_\_ Guardian \_\_\_  
Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Home #: ( ) \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

**2. MEDICAL HISTORY:**

Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_

Has Patient Ever Had:

- |                                    |  |   |
|------------------------------------|--|---|
| <input type="checkbox"/> AIDS      | <input type="checkbox"/> Cerebral Palsy    | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Cold Sores        | <input type="checkbox"/> Injury to Face   |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Lung Disease     |
| <input type="checkbox"/> Allergy   | <input type="checkbox"/> Hearing Problem   | <input type="checkbox"/> Oral Ulcers      |
| <input type="checkbox"/> Bleeding  | <input type="checkbox"/> Heart Condition   | <input type="checkbox"/> Previous Surgery |
|                                    |  | <input type="checkbox"/> Rheumatic Fever  |

Specify: \_\_\_\_\_  
\_\_\_\_\_

Other Illness: \_\_\_\_\_

- Is the patient receiving any medication?  Yes  No  
 Is the patient allergic to any medication?  Yes  No  
 Is the patient allergic to anything else?  Yes  No

Specify: \_\_\_\_\_

Does the patient need to be premedicated (antibiotics) for routine dental procedures?  Yes  No

If yes, specify and give reason for use \_\_\_\_\_

Have the patient's tonsils and/or adenoids been removed?  Yes  No

If yes, at what age? \_\_\_\_\_ Years

Other operations  Yes  No

If yes, describe \_\_\_\_\_  
\_\_\_\_\_

**3. DENTAL HISTORY:**

Family Dentist \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_

Date of last dental examination \_\_\_\_\_

Injuries or trauma to the teeth or gums?  Yes  No

If yes, please specify \_\_\_\_\_

- How often does the patient brush his/her teeth?  
 Several times a day  Occasionally  
 Once or twice a day  Never

Has the patient ever had:

Unfavorable dental experiences? ( ) Yes ( ) No

Specify \_\_\_\_\_

Speech Therapy? ( ) Yes ( ) No

Does or did the patient

Grind his/her teeth at night? ( ) Yes ( ) No

Bite his/her fingernails? ( ) Yes ( ) No

Suck thumb, finger, pacifier, etc.? ( ) Yes ( ) No

If yes, at what age did he/she discontinue? \_\_\_\_\_ Years

Does the patient's home water supply have fluoride? ( ) Yes ( ) No

**4. PATIENT'S TREATMENT ATTITUDE:**

Is the patient aware of an orthodontic problem? ( ) Yes ( ) No

Orthodontic consultation was prompted by \_\_\_\_\_

The patient's interest in orthodontic treatment is:

( ) Wants treatment

( ) Willing if treatment is necessary

( ) Unwilling

**5. OTHER:**

Describe the main reason why you are, or your child is, seeking orthodontic treatment

\_\_\_\_\_  
Signature of individual completing this form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**6. Whom may we thank for referring you to our office?** \_\_\_\_\_