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ORTHODONTIST
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PATIENT INFORMATION & MEDICAL QUESTIONNAIRE

Patient's Name_____ Nickname_____
First Middle Last

Address_____

City_____ State_____ Zip_____ Phone_____

Cell Phone _____ Email Address_____

Date of Birth _____ Hobbies/Sports _____

School _____

Mother's Name_____ SS#_____ Occupation _____

Employer_____ Work Phone _____

Father's Name_____ SS#_____ Occupation _____

Employer_____ Work Phone _____

Other Children (names/ages) _____

Name of Person(s) Financially Responsible For This Account _____

Address _____ Phone _____

Additional Person to Contact In An Emergency _____

Address _____ Phone _____

Name of Dentist _____ Address _____

Last Visit to Dentist_____ Last Dental Cleaning _____

Name of Physician _____ Address _____

Who referred you to our office?_____

Were you aware of any orthodontic problem prior to the referral? _____

Explain patient's/parents' orthodontic concerns _____

Explain dentist's orthodontic concerns _____

_____

Has any other orthodontist been consulted? _____

Patient's general health: Excellent_____ Good_____ Fair_____ Poor_____

Does patient need to take **antibiotics** prior to a dental visit? Yes____ No____

Does patient's jaw ever make grating sounds? Yes____ No____

Does patient's jaw ever "lock" upon opening or closing? Yes____ No____

Does patient have pain in jaw upon opening or closing? Yes____ No____

Does patient ever have "ringing in the ears"? Yes____ No____

Does patient have TMJ? Yes____ No____

Did patient ever have any accidents to the teeth or jaws? Yes____ No____

Does patient get headaches often (more than one per week)? Yes____ No____

Allergies (penicillin, dental anesthetic, aspirin, latex {rubber gloves}, etc.)_____

_____

Is the patient now taking any medication (pills, drugs, injections, etc.)_____

_____

Does the patient bite his/her nails? Yes____ No____

Does the patient suck his/her thumb or fingers? Yes____ No____

Females Only: Is the patient pregnant? Yes____ No____

Does the patient have or has the patient ever had any of the following? Please circle:

Anemia	Yes	No	**Heart Murmur**	Yes	No
Asthma	Yes	No	Hemophilia	Yes	No
AIDS or ARC	Yes	No	Hepatitis	Yes	No
Bleeding Tendency	Yes	No	Hives	Yes	No
Blood Disorders	Yes	No	Jaundice	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No
Low Blood Pressure	Yes	No	Liver Disease	Yes	No
Cancer	Yes	No	Mitral Valve Prolapse	Yes	No
Cold Sores	Yes	No	Pneumonia	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Epilepsy	Yes	No	Venereal Disease	Yes	No
Bleeding/Sore Gums	Yes	No	Hay Fever	Yes	No
Heart Disease	Yes	No	Persistent Cough	Yes	No
Tuberculosis	Yes	No	Cough Up Blood	Yes	No

Other Medical Conditions. Please specify_____

_____

I understand and agree that I am financially responsible for the balance of my account for any professional services rendered regardless of my insurance. I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct, and I will notify you of any changes. I also authorize the release of information and assign insurance benefit payments to the doctor.

Signature_____ Date_____

(Parent or Guardian if minor)