



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 () _____

DOES PATIENT HAVE INSURANCE FOR ORTHODONTIC TREATMENT? () Yes () No

1. FAMILY STATUS:

Father's Name _____ Work Phone _____

Mother's Name _____ Work Phone _____

2. MEDICAL HISTORY:

Family Physician _____ Phone () _____

Address _____

Has Patient Ever Had:

- | | | |
|---------------|-----------------------|----------------------|
| () AIDS | () Cerebral Palsy | () Hepatitis |
| () Anemia | () Cold Sores | () Injury to Face |
| () Arthritis | () Diabetes | () Kidney Disease |
| () Asthma | () Epilepsy/Seizures | () Lung Disease |
| () Allergy | () Hearing Problem | () Oral Ulcers |
| () Bleeding | () Heart Condition | () Previous Surgery |
| | | () 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: _____