

Orthodontic Acquaintance Questionnaire

DIPLOMATES AMERICAN BOARD OF ORTHODONTICS

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We are pleased that you called our office for your orthodontic treatment. Your appointment will take approximately one hour. We have enclosed this questionnaire in order to help us with your diagnosis and treatment planning. **Please complete the entire questionnaire on both sides.** Email reminders for appointments are provided as a courtesy to all patients/parents. Fill in your address where appropriate. We look forward to meeting you at your appointment.

Please provide us with the following patient information: Date: _____

Patient _____ Nickname _____ SS# _____

Address _____ Birthdate ____/____/____ Age _____

Male ____ Female ____ Home phone (____) _____ Email address _____

If appropriate, what school do you attend? _____

Responsible Party: _____ Marital Status _____

Address _____ Birthdate ____/____/____ SS# _____

Employer _____ Occupation _____ Work phone _____

Address _____ email address _____

Spouse/Parent Name _____ SS# _____ Birthdate ____/____/____

Employer _____ Occupation _____

Address _____ email address _____

*****PLEASE BRING A COPY OF YOUR DENTAL INSURANCE CARD TO YOUR APPOINTMENT*****

Dental Insurance Information: Insured's Name _____ SS# _____

Birthdate ____/____/____ Employer _____ Insurance Co _____ Ins phone # _____

Adult Orthodontic Coverage over age 19? ____ Yes ____ No Max Coverage \$ _____

Do you have dual coverage? ____ Yes ____ No If yes: Insured's Name _____

SS # _____ Birthdate ____/____/____ Insurance Co _____ Phone # _____

Employer _____ Adult coverage over age 19? Yes ____ No ____ Max Coverage \$ _____

I certify that the above information is correct and current. Where appropriate, credit bureau reports may be obtained. I authorize the release of any photographs or x-rays taken regarding treatment for use in lectures or demonstrations.

Signature (parent signature if minor) _____ Date _____

PATIENT DENTAL HISTORY

General Dentist _____ Address _____
Street City State Zip

Reason for orthodontic consultation _____

Have you had Regular dental checkups Extractions Previous orthodontic consultation or treatment _____

Any family member requires or receives orthodontic treatment?

Please check if there is a history of:

- | | | |
|---|--|---|
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Jaw joint soreness | <input type="checkbox"/> Thumb (finger) sucking |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Jaw joint clicking | <input type="checkbox"/> Tongue thrusting |
| <input type="checkbox"/> Muscular soreness around head and neck | <input type="checkbox"/> Jaw joint popping | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Headaches More than Normal | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Lip Biting |

PATIENT MEDICAL HISTORY

Physician _____ Address _____

Present state of health Excellent Good Fair Poor

Do you have any general health problems? No Yes

If so, please specify _____

Are you currently under a Physician's care No Yes

If so, please specify _____

Please list current drugs/medications _____

List any drug allergies or sensitivity _____

Please check if you have a history of (check appropriate boxes)

- | | | |
|---|---|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Repeated sore throats/colds | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Mouth Breathing
(awake or asleep) | <input type="checkbox"/> Difficulty in Chewing or
Swallowing | <input type="checkbox"/> Prosthetic implants |
| <input type="checkbox"/> Speech Impediments | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Aids/HIV |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Asthma, hay fever, allergies, _____ | | <input type="checkbox"/> Anemia |

Heart Condition? No Yes Pre-medication required? List medication _____

Tonsils removed? Date _____ Latex allergy

Adenoids removed? Date _____ Nickel allergy

Whom may we thank for this referral? Please list dentist, patients and friends:

If child, please list names and birthdates of brothers and sisters

NAME	BIRTHDATE
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_____	_____
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_____	_____
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