Welcome to Our Practice!

Form 401B

Orthodontic Questionnaire

OFFICE USE
Patient # _____

Today's Date: _____

PATIENT INFORMATION

☐ Mr. ☐ Ms ☐ Miss ☐ Mrs. ☐ Dr.

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS # _____

Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Dependent

RESPONSIBLE PARTY
IF OTHER THAN PATIENT

Relationship to patient _____

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS # _____

Birth Date _____ Age _____

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

EMPLOYMENT INFORMATION

Employer _____

Work Phone _____

Occupation _____

How Long at Current Job? _____

INSURANCE

Insurance Company _____

Address _____

City/State/Zip _____

Phone # _____

Insured's Employer _____

Insured's Name _____

Relationship to Patient _____

Insured's SS # or Membership # _____

POLICY / GROUP NUMBER _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

_____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

PHONE# _____

FAMILY PHYSICIAN _____

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE PAST 9 MONTHS

PRACTITIONER	SPECIALTY	APPROXIMATE DATE OR TREATMENT

Patient Signature _____ Date _____

REASON FOR VISIT

- ☐ Accident
- ☐ "Buck" or Protruding Teeth
- ☐ Clicking of Jaw Joint
- ☐ Crowded Teeth
- ☐ Facial Pain
- ☐ Gum Disease or Recession
- ☐ Head Pain
- ☐ Irregular Facial Proportions
- ☐ Irregularly Shaped Teeth
- ☐ Jaw Dysfunction
- ☐ Jaw Pain
- ☐ Mismatched Bite
- ☐ Missing Tooth
- ☐ Missing Teeth
- ☐ Neck Pain - Frequent
- ☐ Orthodontic Second Opinion
- ☐ Overbite
- ☐ Overly Small Mouth
- ☐ Prominent Jaw
- ☐ Receded Jaw
- ☐ Tooth Spacing - Excessive

Other _____

MEDICATIONS CURRENTLY BEING TAKEN

Yes ☐	*No* ☐	Antibiotics	*Yes* ☐	*No* ☐	Insulin
Yes ☐	*No* ☐	Anticoagulants	*Yes* ☐	*No* ☐	Muscle relaxants
Yes ☐	*No* ☐	Barbiturates	*Yes* ☐	*No* ☐	Nerve pills
Yes ☐	*No* ☐	Blood thinners	*Yes* ☐	*No* ☐	Pain medication
Yes ☐	*No* ☐	Codeine	*Yes* ☐	*No* ☐	Sleeping pills
Yes ☐	*No* ☐	Cortisone	*Yes* ☐	*No* ☐	Sulfa Drugs
Yes ☐	*No* ☐	Diet Pills	*Yes* ☐	*No* ☐	Tranquilizers
Yes ☐	*No* ☐	Heart Medication			

Other _____

For Office Use

_____

_____

_____

Patient Signature _____ Date _____

MEDICAL HISTORY

Yes ☐ No ☐ Adenoids have been removed

Yes ☐ No ☐ Tonsils have been removed

Yes ☐ No ☐ Allergy to: ☐ Latex ☐ Metals ☐ Plastic

Yes ☐ No ☐ Asthma

Yes ☐ No ☐ Autoimmune Disorders

Yes ☐ No ☐ Bleeding of Gums

Yes ☐ No ☐ Blood Pressure ☐ HIGH ☐ LOW

Yes ☐ No ☐ Blood Sugar ☐ HIGH ☐ LOW

Yes ☐ No ☐ Cancer

Yes ☐ No ☐ Convulsions/Epilepsy ☐ Convulsions ☐ Epilepsy

Yes ☐ No ☐ Diabetes

Yes ☐ No ☐ Endocrine Disorders (thyroid, adrenal, pituitary or other glands)

Yes ☐ No ☐ Facial Pain

Yes ☐ No ☐ Headaches

Yes ☐ No ☐ Hearing Impairment

Yes ☐ No ☐ Heart ☐ Disorder ☐ Heart Disorder and Murmur ☐ Murmur

Yes ☐ No ☐ Hemophilia

Yes ☐ No ☐ Hepatitis

Yes ☐ No ☐ Injury to: ☐ Face ☐ Head ☐ Mouth ☐ Neck ☐ Teeth

Yes ☐ No ☐ Jaw Pain

Yes ☐ No ☐ Kidney Problems

Yes ☐ No ☐ Muscle Aches

Yes ☐ No ☐ Neck Pain

Yes ☐ No ☐ Prior Orthodontic Treatment

Yes ☐ No ☐ Rheumatic Fever

Yes ☐ No ☐ Ringing of the Ears

Yes ☐ No ☐ Shortness of Breath

Yes ☐ No ☐ Sinus Problems

Yes ☐ No ☐ Snoring

Yes ☐ No ☐ Speech Difficulties

Yes ☐ No ☐ Tendency for: ☐ Colds ☐ Ear Infections ☐ Sore Throats

Yes ☐ No ☐ Tuberculosis

Other _____

For Office Use

_____

_____

_____

Patient Signature _____ _____

TENDENCIES

Clenching/Grinding Teeth: *Yes* ☐ *No* ☐ Frequent *Yes* ☐ *No* ☐ Occasional

Lip Biting *Yes* ☐ *No* ☐ Frequent *Yes* ☐ *No* ☐ Occasional

Yes ☐ *No* ☐ Mouth Breather Habitual

Yes ☐ *No* ☐ Nail Biter - Frequent

Thumb Sucking *Yes* ☐ *No* ☐ Current *Yes* ☐ *No* ☐ Prior

Finger Sucking *Yes* ☐ *No* ☐ Current *Yes* ☐ *No* ☐ Prior

Other _____

For Office Use

_____

_____

_____

OPERATIONS / HOSPITAL STAYS

_____

_____

AUTHORIZATION

The undersigned affirm that the information given in this questionnaire is true and accurate to the best of my knowledge. I authorize staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company or for legal documentation.

I accept full responsibility for all charges for treatment to the patient regardless of insurance coverage.

Signature _____ *Date* _____ *Relationship*

☐ Patient ☐ Parent

☐ Guardian ☐ Other