ADULT ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name:_____ Preferred name:_____
Last First MI
Date of Birth:_____ Sex: M F E-mail address:_____

Address: Street:_____ City:_____

State:_____ Zip:_____ Home Telephone: (____)_____

Cell:(____)_____ Work:(_____)_____

Occupation:_____ Employer:_____

Why are you seeking orthodontic treatment? (Please be as specific as possible):

_____

_____

Who may we thank for referring you to our office? _____

FAMILY STATUS

Are you married? Yes No Spouses name: _____

Spouse's Occupation:_____ Employer:_____

Spouse's cell phone: (____)_____ Work Phone: (_____)_____

INSURANCE INFORMATION

Will you be using dental insurance? Yes No

If yes, please provide the following

Insurance company:_____ Group Number:_____

Telephone Number: (_____)_____

Name of Subscriber: _____ Employer:_____

Subscriber's Date of Birth_____ SS#_____

DENTAL HISTORY

General Dentist:_____ City_____

Date of last dental examination: _____

Have you ever had trauma/damage to the jaws, teeth, or gums?_____

Have you ever had orthodontic treatment before? Yes No

Have you had a previous orthodontic consultation? Yes No Where_____

Please circle all that apply:

My reason for seeking treatment is: Esthetic Functional Health Related

Please rate the following on a scale from 1-10 (10 being the highest or best):

I think my current state of dental health is a: 1 2 3 4 5 6 7 8 9 10

The current appearance of my teeth is a: 1 2 3 4 5 6 7 8 9 10

The value I place on a beautiful smile is a: 1 2 3 4 5 6 7 8 9 10

My motivation for maintaining and improving my teeth is a: 1 2 3 4 5 6 7 8 9 10

The priority I am currently placing on my smile is a: 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Family Physician:_____Phone (_____)_____

Address:_____

Are you currently under a physician's care? Yes No

If yes, please explain

_____

Are you taking any medicine at this time? Yes No

If yes, please list _____

Are you allergic to any medications? Yes No If yes, please list _____

Do you have any other allergies? Yes No If yes, please list _____

Do you need to be premedicated (with antibiotics) for routine dental procedures? Yes No

If yes, please specify and give reason for this need: _____

Have you ever been hospitalized? Yes No If yes, please explain

_____

Females: Are you pregnant? Yes No

Do you have or have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV+	☐	☐	Cold Sores	☐	☐	Injury to head
☐	☐	Anemia	☐	☐	Rheumatic Fever	☐	☐	Kidney Disease
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Lung Disease
☐	☐	Asthma	☐	☐	Epilepsy/Seizures	☐	☐	Previous Surgery
☐	☐	Oral Ulcers	☐	☐	Hearing Problem	☐	☐	Psychological Therapy
☐	☐	Birth Defects	☐	☐	Heart Condition	☐	☐	Radiation or cancer therapy
☐	☐	Bleeding Disorder	☐	☐	Speech Therapy	☐	☐	Tonsils/Adenoid Surgery
☐	☐	Cerebral Palsy	☐	☐	Hepatitis	☐	☐	Injury to face/teeth/gums

Do you have any disease, condition, or problem not listed above? Please explain:

_____

_____

_____

Thanks for your help. We're excited to get to know you better!

Signature:_____ Today's Date:_____