NEW PATIENT QUESTIONAIRE

The following questions are designed to obtain your health history and to help us understand what you want to achieve from orthodontic treatment. We will confirm this information when we present your treatment options.

Patient

Date_____

Patient's last name_____ First name_____ MI_____

Birth date_____ Gender: Male Female Social Security #_____

School_____ Grade_____

Home Address_____

City, State, Zip code_____

Email address(es)_____

Home phone_____ Cell phone_____

Parent/Guardian

Name(s)_____

Patient lives with_____

Father's full name_____

Occupation_____ Email address_____

Address (if different)_____

Home phone (if different)_____ Cell phone_____

Mother's full name_____

Occupation_____ Email address_____

Address (if different)_____

Home phone (if different)_____ Cell phone_____

Dentist

Patient's Dentist_____ Last Seen_____

Address, City, State_____

Other dentists/specialists being seen_____

Reason_____

MY CHIEF CONCERNS ARE:

_____

CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT:

The Teeth

- ❍ There are spaces between the teeth that I do not like.
- ❍ The teeth are crooked and overlapping.
- ❍ The teeth stick out too far.
- ❍ The mouth seems too small, not enough room for the teeth.
- ❍ The teeth are coming in the wrong places.
- ❍ Not aware of any problems.
- ❍ Other_____

The Bite

- ❍ The bite is comfortable and I can eat what I want with no difficulties.
- ❍ I feel there is a problem with the bite or I have been told there is a problem.
- ❍ I have frequent or chronic pain in my jaws, face or head.
- ❍ My jaws click, pop, or lock when I open my mouth.
- ❍ I have or have had difficulty in opening and/or closing my jaws.
- ❍ I clench my teeth during the day or grind my teeth during the night.
- ❍ Other_____

The Orthodontist

- ❍ This is my first experience with an orthodontist.
- ❍ The patient has worn braces before. _____ (year)
- ❍ The patient has a family member that has or has had braces.
- ❍ I have seen another orthodontist and I would like a second opinion.

What I Expect from Orthodontic Treatment

- ❍ I want all the teeth straightened and the bite corrected if possible.
- ❍ I want the lower teeth straightened and aligned.
- ❍ I only want the upper teeth straightened and aligned.
- ❍ I only want to find out if any treatment is needed.
- ❍ Other_____

How Soon Would You Like to Get Started?

- ❍ I would like to get started as soon as possible if it is determined that treatment is indicated.
- ❍ I want to meet with the orthodontist to discuss the results of the diagnosis before making a decision.
- ❍ I want to discuss the findings with my spouse before making a decision to start treatment.
- ❍ I want to delay treatment as long as possible.

Dental Insurance

Primary policy holder's full name_____ Birth date_____

Social Security #_____ Relationship to patient_____

Address and phone (if not listed above)_____

Insurance Company_____ Group #_____ ID #_____

Does this policy have orthodontic benefits? ❍Yes ❍No ❍Don't Know

Medical History

Physician

Patient's Physician _____Last Exam_____

Address, City, State_____

Other specialists being seen_____

Reason_____

Now or in the past has the patient had:

Y	N	Un	
❍	❍	❍	Birth defects or hereditary problems?
❍	❍	❍	Any injuries to face, head, neck?
❍	❍	❍	Frequent headaches or migraines
❍	❍	❍	High or low blood pressure?
❍	❍	❍	Heart disease_____
❍	❍	❍	Excessive bleeding or bruising, anemia?
❍	❍	❍	Asthma?
❍	❍	❍	Allergies? _____
❍	❍	❍	Tonsils or adenoid condition?
❍	❍	❍	Vision, hearing, or speech problems?
❍	❍	❍	Frequently breathe through mouth or snore?
❍	❍	❍	Arthritis or joint problems?
❍	❍	❍	Endocrine or thyroid problems?
❍	❍	❍	Diabetes?
❍	❍	❍	Kidney problems?
❍	❍	❍	Hepatitis, jaundice, or other liver problems?
❍	❍	❍	Immune system problems?
❍	❍	❍	Seizures, fainting spells, neurologic problems?
❍	❍	❍	History of osteoporosis?
❍	❍	❍	Cancer, tumor, radiation treatment or chemotherapy?
❍	❍	❍	Medications, including supplements, non-prescription?_____

Dental History

Y	N	Un	
❍	❍	❍	Baby teeth or adult teeth removed?
❍	❍	❍	Extra or missing teeth?
❍	❍	❍	Injury to teeth?

❍ ❍ ❍ Frequent oral habits (sucking finger, chewing pen, etc.)?

❍ ❍ ❍ Clicking, locking, pain in jaw joints?

❍ ❍ ❍ Tooth grinding or clenching?

❍ ❍ ❍ Gum disease?

❍ ❍ ❍ Any sensitive or sore teeth?

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature_____ Date _____