

CONFIDENTIAL ADULT ORTHODONTIC PATIENT QUESTIONNAIRE

PATIENT INFORMATION:

Patient's Name: _____ Sex: M F
Last First MI
Preferred Name: _____ **Birth Date:** _____ **Age:** _____ **SS #:** _____
Address: _____ **City:** _____
State: _____ **Zip:** _____ **Home Phone:** (____) _____
Employer: _____ **Occupation:** _____
Work Phone: (____) _____ **E-Mail Address:** _____
Cell Phone: (____) _____ **What number would you prefer we use to contact you?** _____
Why are you seeking orthodontic treatment? (Please be as specific as possible): _____

Who referred you to our office? _____

FAMILY STATUS: Single Married Widowed Separated Divorced

If married, **Spouse's Name:** Mr./Mrs./Ms./Dr. _____
Employer: _____ **Occupation:** _____
Work Phone: (____) _____ **E-Mail Address:** _____
Cell Phone: (____) _____ **What number should we use to contact them?** _____
 If not married, **name of closest relative:** _____ **Phone:** (____) _____

INSURANCE INFORMATION:

Will you be using dental insurance? ___ Yes ___ No If yes, please provide the following:

Primary Subscriber: _____ **SS#** _____
Date of Birth: _____ **Employer:** _____
Insurance Company: _____ **Group #** _____ **Telephone:** (____) _____
Secondary Subscriber: _____ **SS#** _____
Date of Birth: _____ **Employer:** _____
Insurance Company: _____ **Group #** _____ **Telephone:** (____) _____

DENTAL HISTORY:

General Dentist: _____ **Phone:** (____) _____
Address: _____
Date of last dental examination: _____ **Date of last dental cleaning:** _____
How often do you see your dentist for cleanings? _____ times per year
How often do you brush? _____ times per day **How often do you floss?** _____ times per day
Do your gums bleed when brushing/flossing? Often Occasionally Never
Do you grind your teeth? Yes No If yes, when? At night During the day **Do you wear a bitesplint?** Yes No
Are you currently or have you recently seen a specialist for any dental problems? Yes No
 If yes, please explain: _____
Have you had a previous orthodontic consultation? Yes No
Have you ever had orthodontic treatment before? Yes No If yes, when? _____

Please check all that apply:

My primary reason for seeking treatment is: Esthetic Functional Health related

Please rate the following on a scale of 1 — 10 (10 being 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 currently taking or have you ever taken any oral or IV bisphosphonate drug (eg. Actonel® (risedronate), Boniva® (ibandronate), Fosamax® (alendronate), Skelid® (tiludronate), Didronel® (etidronate), Aredia® (pamidronate), Zometa® (zoledronic acid), Bonfos® (clodronate)? Yes No If yes, reason: _____

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

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

Have you ever been hospitalized? Yes No If yes, please list: _____

Females: Are you pregnant? Yes No

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

Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV+		Birth Defects		Oral Ulcers		Hepatitis		Unfavorable Dental Experience(s)	
Anemia		Bleeding Disorder		Epilepsy/Seizures		Injury to Head		Psychological Therapy	
Arthritis		Cerebral Palsy		Hearing Problem		Kidney Disease		Radiation or Cancer Therapy	
Asthma		Cold Sores		Heart Condition**		Lung Disease		Tonsils/Adenoids Surgery	
Diabetes		Rheumatic Fever		Speech Therapy		Previous Surgery		Injury to Face/Teeth/Gums	

If you have a **heart condition, please specify: _____

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

If yes, reason: _____

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

Doctor's Notes: _____

😊 Thank you for your help! We're excited to get to know you better! 😊

Signature: _____ Today's Date: _____