Members American Association of Orthodontists

OUTSTANDING ORTHODONTICS BERKMAN + SHAPIRO

CONFIDENTIAL ADULT ORTHODONTIC PATIENT QUESTIONNAIRE

PATIENT INFORMATION:

Patient's Name: _____ Sex: M F
Mr./Mrs./Ms./Dr. Last First MI

Preferred Name: _____ Birth Date: _____ Age: _____ SS #: _____

Address: _____ City: _____

State: _____ Zip: _____ Cell Phone: (_____)_____

Employer: _____ Occupation: _____

Work Phone: (_____)_____ E-Mail Address: _____

Home 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? _____

MARITAL 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? _____

(QUESTIONNAIRE CONTINUES ON OTHER SIDE OF SHEET)

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® (zolendronic acid), Bonefos® (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	
☐	☐	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: _____