ADULT ORTHODONTIC QUESTIONNAIRE

Patient's Name _____ Name Preferred _____ Male___ Female____

Primary Tele# _____ ☐Home ☐Cell ☐Other Birthdate _____ Patient's Age _____

Address _____ City _____ State ___ Zip _____

E-mail Address_____

Spouse _____

Your Employer _____ Spouse's Employer_____

Position _____ Position _____

Work Tele# _____ ☐Work ☐Cell Work Tele# _____ ☐Work ☐Cell

Financially Responsible Party

Name_____(male / female) Relationship_____

Address_____ City_____ State_____ Zip_____

Phone#_____(cell / home / office) Date of Birth_____

Driver's Lic#_____ Social Security#_____

Who is your dentist?_____ When was your last dental cleaning? _____

Do you plan to move in the next 12-18 months? _____ How did you hear about us? _____

What is the purpose of today's visit or your chief concern for treatment?_____

_____

Are there problems with your health now? . . . . . Yes No

Recently, have you been treated by a physician? . . . . . Yes No

Have you been told you need antibiotic prophylaxis prior to dental treatment? . . . . . Yes No

Have you ever consulted an **orthodontist**? . . . . . Yes No

Have you ever received **orthodontic** treatment? . . . . . Yes No

Have other family members been treated by this practice? . . . . . Yes No

Please list any medications you are taking: _____

Please place an "X" if the patient **has now or has ever** had the following:

____ Heart defect, trouble, abnormality
____ Sensitive Gag Reflex
____ Emotional or stress related problems
____ Latex Allergy
____ Nickel Allergy
____ Hepatitis or liver problems
____ Convulsions or seizures
____ Fainting spells
____ Nervous condition
____ Excessive bleeding
____ Gum disease
____ Shoulder or neck pains
____ Taking bisphosphonates and/or medication for arthritis
____ Soreness in jaws or teeth
____ Popping or noises in jaw joints
____ Ringing or buzzing noise
____ Difficulty opening or closing
____ Locking jaws open or closed
____ Frequent earaches
____ Frequent headaches
____ Frequent ear infections
____ Tongue thrusting
____ Snoring
____ Asthma, allergies or hay fever (circle)
____ Osteoporosis

The information above is correct and the insurance information is complete.

Patient's Signature_____ Date _____

INSURANCE INFORMATION

Please fill out information for each dental plan that the patient is covered under.

1. Dental Insurance Company _____
   Toll Free Phone # _____
   Subscriber's Name_____Relation to Patient_____
   Subscriber's Social Security #_____
   Subscriber's Date of Birth _____
   Employer _____
   Plan # _____
   Group #_____
   Claim's Address _____
   _____
   _____

2. Dental Insurance Company _____
   Toll Free Phone # _____
   Subscriber's Name_____Relation to Patient_____
   Subscriber's Social Security #_____
   Subscriber's Date of Birth _____
   Employer _____
   Plan # _____
   Group #_____
   Claim's Address _____
   _____
   _____

3. Dental Insurance Company _____
   Toll Free Phone # _____
   Subscriber's Name_____Relation to Patient_____
   Subscriber's Social Security #_____
   Subscriber's Date of Birth _____
   Employer _____
   Plan # _____
   Group #_____
   Claim's Address _____
   _____
   _____