



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: _____ Phone: (____) _____

Address: _____

Date of last dental examination: _____

Have you ever had orthodontic treatment before? Yes No

Have you had a previous orthodontic consultation? Yes No

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 | |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV+ | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> | Injury to head |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Previous Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Problem | <input type="checkbox"/> | <input type="checkbox"/> | Psychological Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Defects | <input type="checkbox"/> | <input type="checkbox"/> | Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> | Radiation or cancer therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Speech Therapy | <input type="checkbox"/> | <input type="checkbox"/> | Tonsils/Adenoid Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | 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: _____