PATIENT INFORMATION FORM DATE______

PATIENT INFORMATION

Name:____
(Last) (First) (Middle)

Address:____
(Street) (Apt. #)

____
(City) (State) (ZIP)

Birth Date:____________________ Email Address of Parent:____________________

Employer/School:____________________ Occupation/Grade:____________________

Home Phone:(_____)____________________ Work Phone:(_____)____________________

Cell Phone:__(_____)____________________

Whom may we thank for referring you to our office?____________________

Dentist's Name____________________ Dentist's Phone:(_____)____________________
(First) (Last)

NOTE: *If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance as a courtesy for any future treatment, insurance information must be filled out completely at the time of your initial examination.*

Do you have orthodontic insurance? No____ Yes____ Carrier:____________________Phone #:__________

Name of Primary Insured:____________________ Primary's Employer:____________________

Primary's Birth Date:________ Primary's Social Security #:____________ Group/Plan No:__________

RESPONSIBLE PARTY INFORMATION

Name:____
(Last) (First) (Middle)

Address:____
(Street) (Apt. #)

____
(City) (State) (ZIP)

Previous Address (if less than 3 years):____________________

Relationship to Patient:____________________

Employer:____________________ Occupation:____________________ No. of Years Employed:_____

Home Phone:(_____)____________________ Work Phone:(_____)____________________

Spouse's Name:____________________ Spouse's Employer:____________________

Spouse's Occupation:____________________ Spouse's Work Phone:(_____)__________

If Patient is a minor parents are: ___Married ___ Divorced ___Separated ___ Single ___ Remarried ___Widowed

EMERGENCY INFORMATION

Name of Nearest Relative Not Living With You:____________________
(Last) (First)

Address:____
(Street) (Apt. #)

____
(City) (State) (ZIP) ( ) Phone Relationship

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

NAME______________________________ DATE______________________________

I. SUBJECTIVE COMPLAINTS AND CONCERNS

A. What are the patient's or parents' main concerns regarding the jaw and teeth?

	Mild	Moderate	Severe
1. Facial Pain	□	□	□
2. Gum Disease/Recession	□	□	□
3. Gum Problems	□	□	□
4. Headaches	□	□	□
5. Jaw Dysfunction	□	□	□
6. Jaw Joint Sounds	□	□	□
7. Jaw Pain	□	□	□
8. Neck Pain	□	□	□
9. Ringing or "Stuffy" Ears	□	□	□

- □ Bad Bite
- □ "Buck" Teeth/ Overjet
- □ Crowding of Upper Teeth
- □ Crowding of Lower Teeth
- □ Crowding of Upper and Lower Teeth
- □ Crossbite
- □ Dentist Recommended Seeing an Orthodontist
- □ Grinding Teeth
- □ Gummy Smile
- □ Impacted Tooth/ Teeth
- □ Improper Tooth Position
- □ Irregular Facial Proportions
- □ Irregular Shaped Tooth/ Teeth
- □ Missing Tooth/ Teeth
- □ Mouth Too Small
- □ Open Bite
- □ Overbite
- □ Prominent Lower Jaw (too 'strong')
- □ Protrusion of Teeth
- □ Recessive Lower Jaw (too 'weak')
- □ Rotations
- □ Small Teeth
- □ Spaces
- □ Thumb/ Finger Habit
- □ Underbite
- □ OTHER______________________________

____

B. Family members with similar problems:

- □ Patient Adopted
- □ Father
- □ Mother
- □ Brother
- □ Sister
- □ OTHER______________________________

II. MEDICAL DENTAL HISTORY

A. Present Health	Good	Fair	Poor
1. Physical	□	□	□
2. Emotional	□	□	□
3. Stress Level	□	□	□

	Yes	No
B. Has the patient reached puberty?	□	□

C. Has the patient ever had any of the following conditions?

- □ Allergies
- □ Arteriosclerosis
- □ Asthma
- □ Autoimmune Disorder
- □ Blood Disease
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Bone Disorders
- □ Cancer
- □ Diabetes
- □ Dizziness
- □ Emotional Problems
- □ Endocrine Problems
- □ Epilepsy
- □ Female Problems
- □ GERD (Acid Reflux)
- □ Hearing Disorders
- □ Heart Disease
- □ Hepatitis
- □ HIV/AIDS/ARC (Circle)
- □ Kidney Disease
- □ Latex Allergy
- □ Rheumatic Fever
- □ Ringing of Ears
- □ Sleep Disturbance (Sleep Apnea)
- □ Trauma (to face, teeth, jaws, or head)
- □ OTHER______________________________

D. MEDICATIONS – Current medications taken by the patient:

- □ Antibiotics
- □ Birth Control Pills
- □ Bisphosphonates (Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa, etc.)
- □ Diet Pills (diuretics)
- □ Heart Pills (digitalis, etc.)
- □ Insulin
- □ Muscle Relaxants (valium, etc.)
- □ Pain Pills (demerol, codeine, etc.)
- □ Sleeping Pills
- □ Tranquilizers or Antidepressants (elavil, valium, etc.)
- □ Vitamins
- □ OTHER______________________________

over

E. ALLERGIES TO MEDICATIONS/FOOD – The patient demonstrates an allergic response to:

- ☐ Antibiotics (specifically)________________________
- ☐ Dairy Products
- ☐ Food Dyes
- ☐ Pain Pills (specifically)________________________
- ☐ Wheat
- ☐ OTHER________________________________

F. OTHER PERTINENT INFORMATION – Has the patient ever had a history of the following?

	Occasionally	Frequently
1. Clicking in Jaw Joint........................	☐	☐
2. Colds...	☐	☐
3. Difficulty Chewing............................	☐	☐
4. Difficulty Swallowing.........................	☐	☐
5. Finger Sucking................................	☐	☐
6. Grinding Teeth................................	☐	☐
7. Headaches.....................................	☐	☐
8. Lip Biting.......................................	☐	☐
9. Mouth Breathing..............................	☐	☐
10. Pain in Jaw Joint............................	☐	☐
11. Smoking.......................................	☐	☐
12. Snoring..	☐	☐
13. Sore Teeth....................................	☐	☐
14. Sore Throats.................................	☐	☐
15. Speech Problems...........................	☐	☐
16. Thumb Sucking..............................	☐	☐
17. Tongue Thrusting...........................	☐	☐
18. Tonsillitis.....................................	☐	☐
19. Other Habits..................................	☐	☐
20. OTHER______________________	☐	☐

III. PATIENTS OR PARENTS ATTITUDE TOWARD TEETH CARE AND OTHODONTIC TREATMENT

A. Regular dental checkups:

- ☐ Twice a year
- ☐ Once a year
- ☐ Only if necessary
- ☐ Never

B. Patient's interest in orthodontic treatment:

- ☐ Eager for treatment
- ☐ Willing if necessary
- ☐ Dreading but agrees
- ☐ Unwilling

C. Orthodontic consultation was prompted by:

- ☐ Patient (Name)________________________________
- ☐ Dentist (Name)________________________________
- ☐ Mother
- ☐ Father
- ☐ Spouse
- ☐ Brother
- ☐ Sister
- ☐ Other relative (Name)__________________________
- ☐ Friend (Name)________________________________
- ☐ OTHER_____________________________________

	Yes	No
D. Has the patient ever had any unusual dental experiences?..........	☐	☐

If yes, please explain:______________________________________

____

	Yes	No
E. Are there any medical, dental, surgical, or psychological problems not covered above?	☐	☐

If yes, please explain:______________________________________

____

	Yes	No
F. Has the patient ever had a previous orthodontic consultation or treatment:?....	☐	☐

Name of the Dr.____

G. Why are you seeking this consultation?

- ☐ To improve dental appearance
- ☐ To improve facial appearance
- ☐ To improve general appearance
- ☐ To improve longevity of teeth
- ☐ To improve self-esteem
- ☐ To reduce facial pain
- ☐ To reduce headaches/neckaches
- ☐ OTHER_________________________________

G. Date of Last Dental Exam (mm/yy) ________________

H. Siblings / Children (Children 18 and Under Only)

Name	***Age***
______________________	_____
______________________	_____
______________________	_____

Comments:

____

____

____

____

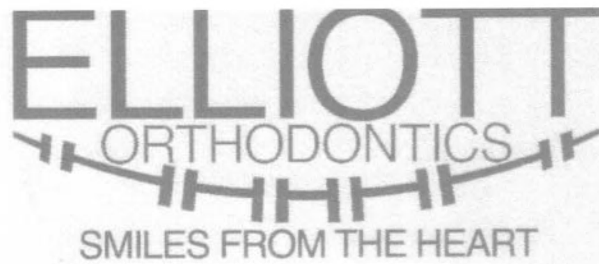
____

____

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice.
If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

____
Patient/ Responsible Party's Signature

____
Date



ADULT AIRWAY EVALUATION

Name ____

Age _____ Sex _____ Weight_________ Height _______

Occupation____

1. Do you breathe through your mouth? Y N Sometimes
2. Do you frequently get a dry throat or non-productive cough? Y N Sometimes
3. Do you have any nasal allergies? Y N Sometimes
4. Do you snore or have you been told you snore while sleeping? Y N Sometimes
5. Do you stop or pause your breathing while sleeping? Y N Sometimes
6. Do you wake up fatigued? Y N Sometimes
7. Do you have morning tension or migraine headaches? Y N Sometimes
8. Do you easily get tired or fall asleep during the day? Y N Sometimes
9. Do you clench or grind the teeth during the night? Y N Sometimes
10. Do you clench or grind the teeth during the day? Y N Sometimes
11. Do you have any facial pain? Y N Sometimes
12. Do you usually drink alcohol or take sleep aids before going to bed? Y N Sometimes
13. Do you suffer from hypertension? Y N
14. Have you been diagnosed with:
    - Chronic Fatigue Syndrome Y N
    - Irritable Bowel Syndrome Y N
    - Fibromyalgia Y N
    - Temporomandibular Joint Syndrome Y N

2/2019