

Welcome to Our Practice!

Form 401B

Orthodontic Questionnaire

Today's Date: _____

OFFICE USE

Patient # _____

PATIENT INFORMATION

Mr. Ms Miss Mrs. Dr.

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone _____ SS # _____

Cell Phone _____

Email _____

Birth Date _____ Age _____ Male

Female

Single

Married

Widowed

Separated

Divorced

Dependent

EMPLOYMENT INFORMATION

Employer _____

Work Phone _____

Occupation _____

How Long at Current Job? _____

INSURANCE

Insurance Company _____

Address _____

City/State/Zip _____

Phone # _____

Insured's Employer _____

Insured's Name _____

Relationship to Patient _____

Insured's Name _____

Insured's Birthdate _____

POLICY / GROUP NUMBER _____

RESPONSIBLE PARTY

IF OTHER THAN PATIENT

Relationship to patient _____

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS # _____

Birth Date _____ Age _____

Male Female

Single

Married

Widowed

Separated

Divorced

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

PHONE# _____

FAMILY PHYSICIAN _____

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE PAST 9 MONTHS

PRACTITIONER

SPECIALTY

APPROXIMATE DATE OR TREATMENT

Patient Signature _____ Date _____

REASON FOR VISIT

- | | |
|---|---|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Mismatched Bite |
| <input type="checkbox"/> "Buck" or Protruding Teeth | <input type="checkbox"/> Missing Tooth |
| <input type="checkbox"/> Clicking of Jaw Joint | <input type="checkbox"/> Missing Teeth |
| <input type="checkbox"/> Crowded Teeth | <input type="checkbox"/> Neck Pain - Frequent |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Orthodontic Second Opinion |
| <input type="checkbox"/> Gum Disease or Recession | <input type="checkbox"/> Overbite |
| <input type="checkbox"/> Head Pain | <input type="checkbox"/> Overly Small Mouth |
| <input type="checkbox"/> Irregular Facial Proportions | <input type="checkbox"/> Prominent Jaw |
| <input type="checkbox"/> Irregularly Shaped Teeth | <input type="checkbox"/> Receded Jaw |
| <input type="checkbox"/> Jaw Dysfunction | <input type="checkbox"/> Tooth Spacing - Excessive |
| <input type="checkbox"/> Jaw Pain | |

Other _____

MEDICATIONS CURRENTLY BEING TAKEN

- | | | | | | |
|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Antibiotics | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Insulin |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anticoagulants | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Muscle relaxants |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Barbiturates | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Nerve pills |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood thinners | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Pain medication |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Codeine | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sleeping pills |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cortisone | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sulfa Drugs |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Diet Pills | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Tranquilizers |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart Medication | | | |

Other _____

For Office Use

Patient Signature _____ Date _____

MEDICAL HISTORY

- Yes No Adenoids have been removed
- Yes No Tonsils have been removed
- Yes No Allergy to: Latex Metals Plastic
- Yes No Asthma
- Yes No Autoimmune Disorders
- Yes No Bleeding of Gums
- Yes No Blood Pressure HIGH LOW
- Yes No Blood Sugar HIGH LOW
- Yes No Cancer
- Yes No Convulsions/Epilepsy Convulsions Epilepsy
- Yes No Diabetes
- Yes No Endocrine Disorders (thyroid, adrenal, pituitary or other glands)
- Yes No Facial Pain
- Yes No Headaches
- Yes No Hearing Impairment
- Yes No Heart Disorder Heart Disorder and Murmur Murmur
- Yes No Hemophilia
- Yes No Hepatitis
- Yes No Injury to: Face Head Mouth Neck Teeth
- Yes No Jaw Pain
- Yes No Kidney Problems
- Yes No Muscle Aches
- Yes No Neck Pain
- Yes No Prior Orthodontic Treatment
- Yes No Rheumatic Fever
- Yes No Ringing of the Ears
- Yes No Shortness of Breath
- Yes No Sinus Problems
- Yes No Snoring
- Yes No Speech Difficulties
- Yes No Tendency for: Colds Ear Infections Sore Throats
- Yes No Tuberculosis

Other _____

<p>For Office Use</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black;"/>

Patient Signature _____

