Welcome to our practice!

Orthodontic Questionnaire

Patient information

Name:_____Male:_____Female:_____
Address:_____
Home #:_____Cell #:_____Day time #:_____
Birth date:_____Age:_____ Email:_____
Employer:_____Work #:_____
Occupation:_____SSN:_____
If under 18, Mother's name:_____Father's name:_____

Responsible party (if other than patient)

Name:_____Relationship to patient:_____
Address:_____
Home #:_____Cell #:_____Work #:_____
Birth date:_____ SSN:_____Day time #:_____

Insurance

Insured's name:_____Relationship to patient:_____
Insured's employer:_____
Insurance company:_____Phone_____
Policy/Group #:_____SSN:_____

Emergency contact_____Phone #_____

Family member names who are patients here_____

Reason for today's visit:_____
_____
_____

Tendencies: Do you do any of the following habits?

Clenching/Grinding: YES_____NO_____ Lip Biting: YES_____NO_____

Mouth breathing: YES_____NO_____ Nail Biting: YES_____NO_____

Snoring: YES_____NO_____

Have you ever finger/thumb sucked?_____If so, until what age_____

Which finger/thumb_____

AUTHORIZATION

The undersigned affirm that the information given in this questionnaire is true and accurate to the best of my knowledge. I authorize staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company or for legal documentation.

I accept full responsibility for all changes for treatment to the patient regardless of insurance coverage.

Signature_____Date_____
Relationship to patient_____