

ORTHODONTIC MEDICAL AND DENTAL QUESTIONNAIRE

PLEASE PRINT CLEARLY AND COMPLETE ALL QUESTIONS:

Patient's Name _____ Age _____ Sex _____
Nickname _____ School _____ Grade _____

If no longer in school, please circle the highest year completed in school:

/1 2 3 4 5 6 7 8/ /1 2 3 4/ /1 2 3 4/ /1 2 3 4 5 6/
Elementary School High College Post-College

Hobbies _____ Pets _____

How many brothers? _____ How many sisters? _____

Do you play a musical instrument? _____ If yes, please name _____

Patient's Dentist _____ Patient's Physician _____

When was the last Dental Check-up? _____

How is the Patient's General Health? _____

Height _____ Weight _____

Does the Patient have any of the following: Diabetes _____ Asthma _____

Convulsions _____ Rheumatic Fever _____

If other, please explain: _____

Are Tonsils and Adenoids present? Yes _____ No _____

Please list any allergies Patient may have (foods, drugs, etc..) _____

Does the Patient have any history of the following:

Thumb Sucking _____ Finger Sucking _____ Lip Biting _____ Nail Biting _____

Is Patient now under a Physician's care? _____ If so, for what reasons? _____

Please list any medication being taken by Patient at the present time _____

Does the Patient have difficulty in chewing or swallowing food? Yes _____ No _____

Has the Patient had an Orthodontic Examination before? _____ If so, when? _____

Has the Patient experienced any unfavorable reactions from previous dental or medical care? _____

Has the Patient had a toothache recently? Yes _____ No _____

Please list any blows or injuries to the face or teeth _____

Does the Patient clench or grind teeth? _____ If so, when? _____

Does the Patient breath through the: Mouth _____ Nose _____ Both _____

Has the Patient noticed any clicking, popping, or pain in the jaw joints? Yes _____ No _____

What is the Patient's Orthodontic problem as you see it? _____

WE WILL BE HAPPY TO SUBMIT YOUR INSURANCE; HOWEVER, PAYMENT IS DUE WHEN SERVICES ARE RENDERED
THANK YOU!!

