
502-426-2744

**ADULT PATIENT QUESTIONNAIRE**

Today's Date _____

FULL NAME _____ NICK NAME _____

DATE OF BIRTH _____ AGE _____ Years _____ Months

SEX ( ) M ( ) F

ADDRESS: Street _____

City _____ State _____ Zip _____

TELEPHONE: Residence ( )_____ Business ( ) _____ Cell ( ) _____

E-MAIL ADDRESS _____

OCCUPATION _____ WHERE _____

**PRIMARY ORTHODONTIC INSURANCE (DENTAL)**

Orthodontic Coverage? Yes ___ No ___ Insurance Co. Name _____

Insurance Co. Address _____ Insurance Co. Phone # ( ) _____

Group # _____ Plan, Local, or Policy # _____

Policy Owner's Name _____ Relationship to Patient _____

Policy Owner's Birth Date ___/___/___ SS# ___-___-_____ Policy Owner's Employer _____

**SECONDARY ORTHODONTIC INSURANCE (DENTAL)**

Orthodontic Coverage? Yes ___ No ___ Insurance Co. Name _____

Insurance Co. Address _____ Insurance Co. Phone # ( ) _____

Group # _____ Plan, Local, or Policy # _____

Policy Owner's Name _____ Relationship to Patient _____

Policy Owner's Birth Date ___/___/___ SS# ___-___-_____ Policy Owner's Employer _____

**1. FAMILY STATUS**

Spouse's Information:

Name _____ Birth Date _____ Home # (  )_____

Employer Name _____ Work # (  )_____ ext.___

E-mail Address _____ Cell # (  )_____

**2. MEDICAL HISTORY**

Family Physician _____ Phone # (  )_____

Address _____

Has Patient Ever Had:

(  ) AIDS (  ) Allergy (  ) Diabetes (  ) Hepatitis (  ) Lung Disease

(  ) Anemia (  ) Bleeding (  ) Epilepsy/Seizures (  ) Injury to Face (  ) Oral Ulcers

(  ) Arthritis (  ) Cerebral Palsy (  ) Hearing Problem (  ) Kidney Disease (  ) Previous Surgery

(  ) Asthma (  ) Cold Sores (  ) Heart Condition (  ) Latex Allergy (  ) Rheumatoid Fever

Specify: _____

_____

Other Illness: _____

_____

Is the patient receiving any medication? (  ) Yes (  ) No

Is the patient allergic to any medication? (  ) Yes (  ) No

Is the patient allergic to anything else? (  ) Yes (  ) No

Specify: _____

Does the patient need to be pre medicated (antibiotics) for routine dental procedures? (  )Yes (  )No

If yes, specify and give reason for use: _____

Have the patient's tonsils and/or adenoids been removed? (  ) Yes (  ) No If yes, at what age? ____

Has the patient had any other operations? (  ) Yes (  ) No

If yes, specify: _____

**3. DENTAL HISTORY**

Family Dentist _____ Phone # (  )_____

Address _____

Date of last dental examination _____

Injuries or trauma to the teeth or gums? (  ) Yes (  ) No

If yes, specify: _____

How often does the patient brush his/her teeth?

(  ) Several times a day (  ) Once or twice a day (  ) Occasionally (  ) Never

Has the patient ever had:

Unfavorable dental experiences? (  ) Yes (  ) No

Specify: _____

Speech therapy? (  ) Yes (  ) No

Does or did the patient:

Grind his/her teeth at night? (  ) Yes (  ) No

Bite his/her fingernails? (  ) Yes (  ) No

Suck thumb, finger, pacifier, etc.? (  ) Yes (  ) No

If yes, at what age did he/ she discontinue? _____

Does the patient's home water supply have fluoride? (  ) Yes (  ) No

**4. PATIENT'S TREATMENT ATTITUDE**

Is the patient aware of an orthodontic problem? (  ) Yes (  ) No

Orthodontic consultation was prompted by _____

The patient's interest in orthodontic treatment is:

(  ) Wants treatment (  ) Willing if treatment is necessary (  ) Unwilling

**5. OTHER**

Describe the main reason why you are seeking orthodontic treatment:

_____

_____

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