



Your Smile Is Our Specialty!

Patient Questionnaire

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____ Own Rent
Street City State Zip

Mailing Address _____
Street City State Zip

Cell Phone _____ Email Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (If less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone () _____ Birthdate _____ Social Security # _____

If patient is a minor, give parents or guardian's name _____

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

INSURANCE INFORMATION

Policy Holder's Name _____ and Soc. Security # _____

Insurance Company _____ Group # _____ Union Local No. _____

Insurance Company Address _____ Insurance Company Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes,

Policy Holder's Name _____ and Soc. Security # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Company Address _____ Insurance Company Phone _____

Policy Holder's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor) _____

Updates (date & initial) _____

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Iowa 52722

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119 South Main St

Maquoketa

Iowa 52060



Member American Association of Orthodontists

MEDICAL HISTORY

For the following questions, please check or fill in the Yes or No square according to whichever applies. Your answers are for our records only and will be considered confidential.

- 1 Are you in good health? Yes No
- 2 Has there been any change in your general health within the past year? Yes No
- 3 Are you under the care of a physician? For what condition? _____
Name of Physician _____ Yes No
- 4 Are you taking any drugs or medicine? Please list: _____ Yes No
- 5 Are you allergic to any medications? Please list: _____ Yes No
- 6 Have your tonsils or adenoids been removed? Yes No
- 7 Are you able to breathe through your nose? Yes No
- 8 Have you had any serious illnesses, accidents or operations?
Please describe: _____
- 9 Do you have any of the following conditions?
- | | | | |
|---|--|-------------------------------|--|
| Rheumatic fever / heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart defects (including murmur) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Persistent cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS / HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma / hayfever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy spells / seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | High / low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis, jaundice or liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic ear pain / infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis / inflammatory rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric counseling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Substance abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies (list: _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- 10 Do you have any health conditions not listed? _____
Please list: _____
- 11 Females only:
- | | | | |
|-------------------|--|-------------------------|--|
| Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Has menstruation begun? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-------------------|--|-------------------------|--|

DENTAL HISTORY

- What was the date of your last visit to the dentist? _____
- Last visit to the dentist: _____ Dentist Name: _____
- Are you aware of any of the following conditions:
- | | | | |
|--|--|--|--|
| Clenching / grinding your teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking / popping in your jaw joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding gums | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain in or around your jaw joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you brush your teeth daily? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Catching / locking of your jaws | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you taking any fluoride supplements? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever injured your face / mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have your wisdom teeth been removed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been treated for TMJ problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any missing / extra teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had previous orthodontic treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke / chew tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you play a musical instrument? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Did you ever suck your thumb / finger? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- If yes, please list instrument: _____
- Please list your chief concern(s) and what you would like treatment to accomplish: _____
- Comments: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the previous information to the best of my knowledge and that all questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health.

Patient Signature (parent/guardian if minor)

Date

Reviewed by