innovative orthodontics
adults | teens | children

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Welcome To Our Office Date_____

We'd like you to help us become better acquainted. So that we can best meet your orthodontic needs, please complete this medical dental questionnaire. When you have finished, let one of our staff know. Thank you!

Patient's Name _____ Home Phone _____ Cell # _____

Birthdate _____ Age _____ Sex _____ Email _____

Home Address _____ City _____ State _____ Zip Code _____

Employed By _____ Business / Cell Phone _____

Address _____ Occupation _____

_____ Spouse's Name _____

Social Security # _____ Driver's License # _____ State _____ Marital Status _____

Spouse's Occupation _____ Spouse's Social Security # _____

Patient's Dentist _____ Patient's Physician _____

Address _____ Address _____

_____

ReferredBy _____

Friend or Relative Who is a Patient In This Office? _____

Person Responsible For Account _____ Phone _____

Billing Address _____ City _____ State _____ Zip Code _____

Emergency Contact Person and Phone: _____

Are You Covered By Dental Insurance That Provides for Orthodontic Treatment?_____

If So, List Name Of Insurance Company, Address, Phone # and Policy Number Below.

_____

Patient Has Been Treated by Physician For

	YES	NO
Artificial Hip or Heart Valve Replacement	❒	❒
AIDS	❒	❒
Anemia	❒	❒
Asthma/Hay Fever	❒	❒
Arthritis	❒	❒
Diabetes	❒	❒
Epilepsy	❒	❒
Fainting/Seizures	❒	❒
Herpes	❒	❒
Hives/Rash	❒	❒
Hyperactivity	❒	❒
Inflammatory Rheumatism	❒	❒
Polio	❒	❒
Nervous Problems	❒	❒
Hepatitis	❒	❒
VD	❒	❒
Heart Problems	❒	❒
Rheumatic Fever	❒	❒
Stomach Ulcers	❒	❒
Tumor or Cancer	❒	❒
TB	❒	❒
Sinus Trouble	❒	❒
Glaucoma	❒	❒
Convulsions	❒	❒
Kidney Problems	❒	❒
Endocrine/Thyroid Problems	❒	❒
Bone Disorders	❒	❒
Prolonged Bleeding/Bleeding Disorders	❒	❒
Liver Problems	❒	❒
Allergies	❒	❒
Thyroid Disease	❒	❒
Removal of Tonsils and Adenoids	❒	❒

Covered Employee's Name _____

Date of Birth _____ Social Security # _____

Employer's Name _____

Address _____

_____

Phone _____

MEDICAL HISTORY

	YES	NO
Patient is in good health	❒	❒
Patient is under physician's care	❒	❒
If so, for what reason _____		
Date of last medical checkup _____		
Are there any impending operations?	❒	❒
If so, describe _____		
Patient is taking prescription medications	❒	❒
If so, list _____		
Patient is allergic to medicines	❒	❒
If so, list _____		
Has puberty been reached (Start of menstruation or voice change)	❒	❒
If so and within last 2 years, when? _____		
Is the patient presently pregnant?	❒	❒

DENTAL HISTORY

	YES	NO	
Patient has had a recent dental check-up	❒	❒	Date: _____
Patient has had a previous orthodontic examination	❒	❒	Date: _____ Whom: _____
Are you a transfer orthodontic patient?	❒	❒	Date treatment started _____

Previous orthodontist name _____

_____

ADDRESS CITY STATE ZIP PHONE

In your own words please explain reason for visit today _____

_____

	YES	NO	
Blow or injury to face or teeth	❒	❒	_____
Finger or thumb sucking habit	❒	❒	_____
Night time teeth clenching or grinding habit	❒	❒	_____
Speech problems	❒	❒	_____
Swallowing problems	❒	❒	_____
Clicking or pain when opening jaws	❒	❒	_____
Ever treated for problems of the jaw joint or facial muscle spasms	❒	❒	_____
Difficulty in breathing through nose	❒	❒	_____
Dentist has removed primary teeth	❒	❒	_____
Dentist has removed permanent teeth	❒	❒	_____
Surgery to repair cleft lip and or cleft palate	❒	❒	_____
Gum disease	❒	❒	_____
High intake of sweets	❒	❒	_____
Parents have had orthodontic treatment	❒	❒	_____
Patient resembles father	❒	❒	_____
Patient resembles mother	❒	❒	_____
Patient is adopted	❒	❒	_____
I feel orthodontics is needed for one or all of these reasons	❒	❒	_____
To improve chewing efficiency	❒	❒	_____
To improve facial appearance	❒	❒	_____
To improve long term dental health	❒	❒	_____

Other _____

Patient's reaction to orthodontic treatment is:

Eager	❒	❒	_____
Complacent	❒	❒	_____
Accepts whatever is recommended	❒	❒	_____
Antagonistic	❒	❒	_____

Other _____

Please describe the patient's individual character or nature (for example, quiet, outgoing, self-conscious, responsible leader, one of the group, etc.)

_____

_____

If you have any additional concerns or questions you wish the doctors to be aware of or you wish the doctors to answer, please describe:

_____

_____

To the best of my knowledge, the above information is correct. I give consent for the initial exam and for records, if needed, to determine the necessity of orthodontic treatment and accept responsibility for payment of records, which includes x-rays, models and photographs. In addition, I understand those records may be used for professional reference, display, promotional advertisement for orthodontic journals, books, meetings, internet ie. website, YouTube, and the like, and patient education. I give my permission to Dr. Wendy Katz's office to obtain a credit report on me, if credit is extended to me for orthodontic treatment.

_____ _____

DATE SIGNATURE OF PERSON COMPLETING FORM

_____ _____

DATE SIGNATURE OF PERSON COMPLETING FORM