innovative orthodontics
adults | teens | children

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Welcome To Our Office: 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 ______ (LAST, FIRST, MIDDLE) Nickname ______ Birthdate ______ (MO. DAY YR.) Age ______

Home Address ______ (STREET, CITY, STATE, ZIP)

How Many Years At This Address? ______ Home Phone ______ School & Grade ______ Sex ______

Patient's Interests: ______ ______ ______ Email ______
(SPORTS, HOBBIES, MUSIC, CHURCH, SCHOOL ACTIVITIES ETC.)

Brothers' Age ____ ____ ____ ____ Sisters' Age ____ ____ ____ ____ (CIRCLE AGES THAT HAVE HAD OR ARE HAVING ORTHODONTIC TREATMENT)

Patient's Dentist ______ Patient's Physician ______ Referred by ______
Address ______ Address ______ Address ______

Close Friend Or Relative Who Is A Patient In This Office ______

Father/Husband Birth Date: ______

Name ______ (LAST, FIRST, MIDDLE)
Address (If Different From Patient) ______ (STREET)
______ (CITY, STATE, ZIP)
Employed By ______
Employer's Address ______
______ Email ______
Occupation ______ Social Security No. ______
How Long Employed? ____ Driver's License # ______ State ______
Phone ______ (HOME (IF DIFFERENT FROM PATIENT)) ______ (BUSINESS / CELL PHONE)

Mother/Wife Birth Date: ______

Name ______ (LAST, FIRST, MIDDLE)
Address (If Different From Patient) ______ (STREET)
______ (CITY, STATE, ZIP)
Employed By ______
Employer's Address ______
______ Email ______
Occupation ______ Social Security No. ______
How Long Employed? ____ Driver's License # ______ State ______
Phone ______ (HOME (IF DIFFERENT FROM PATIENT)) ______ (BUSINESS / CELL PHONE)

Person Responsible For Account ______ (NAME) Billing Address (Street) ______

Does Patient Live With Mother and Father? ❒ Yes ❒ No With Whom? ______ City ______ State ______ Zip ______

Whom Shall We Contact If Unable to Reach Mother Or Father? ______

Patient Has Been Treated by Physician For	**YES**	**NO**
Artificial Hip or Heart Valve Replacement	❒	❒
AIDS	❒	❒
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	❒	❒

Are You Covered By Dental Insurance That Provides For Orthodontic Treatment? ______
If So, List Name of Insurance Company And Policy Number ______
______
Covered Employee's Name ______
Date of Birth ______ Social Security No. ______
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 jaw	❒	❒	____________
Ever treated for problems of the jaw joint or facial muscle spasms	❒	❒	____________
Difficulty in breathing through nose	❒	❒	____________
Dentist has removed primary 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