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PATIENT HEALTH QUESTIONNAIRE FOR:_____ DOB:_____
Date: _____

Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

CHIEF CONCERN(S):
_ Crowded teeth
_ Over bite
_ "Buck teeth"
_ Receded jaw
_ Prominent jaw
_ Gummy smile
_ Spacing between teeth
_ Gum disease/recession
_ Missing teeth
_ Jaw dysfunction
_ Mouth too small
_ Clicking jaw joint
_ Irregular teeth
_ Protrusion of teeth
_ Ears Ring/Stuffy
_ Headache/Face pain
_ Neck pain
_ Jaw pain
_ Irregular facial appearance
_ Other: _____

FAMILY MEMBERS WITH SIMILAR CONDITION:
_ Father _ Mother _ Brother _ Sister
_ Other: _____

PARENTS' MARITAL STATUS
(if patient is a minor):
_ Married _ Divorced
_ Separated _ Single
_ Widowed _ Other: _____

PATIENT'S CURRENT PHYSICAL HEALTH:
_ Excellent _ Good
_ Fair _ Poor

PATIENT'S CURRENT EMOTIONAL HEALTH:
_ Excellent _ Good _Fair _ Poor

KNOWN OR SUSPECTED ALLERGIES:
_ Antibiotics: _____
_ Pain pills: _____
_ Foods: _____
_ Environmental allergies: _____
_ Latex
_ None
_____ PLEASE INITIAL

CONDITIONS THE PATIENT HAS OR HAS HAD:
_ AIDS
_ Allergies
_ Asthma
_ Autoimmune disorders
_ Blood disease
_ High blood pressure
_ Low blood pressure
_ Bone disorders
_ Cancer
_ Diabetes
_ Dizziness
_ Eating disorders
_ Endocrine problems
_ Emotional problems
_ Female problems
_ HIV positive status
_ Hepatitis
_ Heart disease
_ Heart murmur
_ Hearing disorder
_ Kidney disease
_ Rheumatic fever
_ Ringing of the ears
_ Sleep disturbance
_ History of trauma
_ Teeth _ Face _ Jaws _ Head
_ None of the Above
_____ PLEASE INITIAL

CURRENT MEDICATIONS:
_ Heart pills
_ Antibiotics: _____
_ Diet pills
_ Pain pills: _____
_ Vitamins
_ Birth control pills
_ Muscle relaxants
_ Insulin
_ Other: _____
_ None
_____ PLEASE INITIAL

HAS (CHILD) PATIENT REACHED PUBERTY:
_ Yes, approximate date: _____
_ No

PRIMARY BREATHING PATTERN:

_ Mouth _ Nose
_ Depends on _____

DOES THE PATIENT SNORE WHEN SLEEPING?

_ Yes _ No
_ Sometimes: _____

DIFFICULTY CHEWING?

_ Yes
  _ Teeth don't meet well
  _ Pain when chewing
  _ Other: _____
  _ No

CHECK ALL THAT APPLY:

_ Frequent sore throat/tonsillitis
_ Speech problems
_ Pain in the RIGHT jaw joint
_ Pain in the LEFT jaw joint
_ Clicking/popping in RIGHT jaw joint
_ Clicking/popping in LEFT jaw joint
_ Current thumb/finger sucking habit
_ Previous thumb/finger sucking habit
_ Lip biting/sucking habit
_ Grind teeth
_ Clench jaws
_ Tongue thrust when swallowing

Has the patient had a previous orthodontic exam/consult? _____Yes _____No

Please note your email address so we can send important information & appointment reminder:

_____

FREQUENCY OF DENTAL CHECKUPS?

_ Once per year
_ Twice per year
_ More than twice a year
_ Emergencies only
_ Never

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

_ Wants treatment
_ Only if necessary
_ Unwilling
  But will cooperate if treatment is needed
_ Uncooperative

ORTHODONTIC EXAM PROMPTED BY:

_ Patient _ Mother _ Spouse
_ Dentist _ Father _ Sibling
_ Doctor _ Friend _ Other

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?

_ Yes, please describe: _____

_____

_____

***NAME OF MEDICAL DOCTOR:**

_____

***PATIENT GENERAL DENTIST:**

Name:
Phone#:
Address:

_____ _____ _____

Responsible Party Signature | Printed Name | Date

PATIENT DENTAL INSURANCE INFORMATION:

Patient name: _____

Employee: _____

Social Security Number of Employee: _____ **Birth Date:** _____

Employer: _____ **Union No.** _____

Group Name: _____ **Group No.** _____

Primary Dental Carrier Name: _____ **Policy No.** _____

Secondary Dental Carrier Name: _____ **PolicyNo.** _____