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ORTHODONTIC EXAMINATION QUESTIONNAIRE

Date _____ A B C

Patient s Name _____ Nickname _____ Birthdate _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip _____

School _____ Grade _____ Weight _____ Height _____

RESPONSIBLE PARTY INFORMATION

Father s Full Name _____ Birthdate _____ Age _____

Address _____ How Long? _____

City _____ State _____ Zip _____

Previous Address (if less than 3 years) _____

Home Phone _____ Work Phone _____

Employed By _____ Occupation _____ How Long? _____

Social Security Number _____/ _____/_____ Marital Status _____

Is orthodontic insurance a benefit of this company? _____ Group # _____

INSURANCE COMPANY _____

ADDRESS _____ PHONE NUMBER _____

Mother s Full Name _____ Birthdate _____ Age _____

Address _____ How Long? _____

City _____ State _____ Zip _____

Previous Address (if less than 3 years) _____

Home Phone _____ Work Phone _____

Employed By _____ Occupation _____ How Long? _____

Social Security Number _____/ _____/_____ Marital Status _____

Is orthodontic insurance a benefit of this company? _____ Group # _____

INSURANCE COMPANY _____

ADDRESS _____ PHONE NUMBER _____

EMAIL ADDRESS (of person responsible for appointments) _____

Please sign both areas for insurance billing.

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____ _____
SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

_____ _____
SIGNED (INSURED PERSON) DATE

Child Lives With _____ Names and ages of other children in the family? _____

_____

Names of any family members that have been patients previously _____

MEDICAL HISTORY

PHYSICIAN: (full name) PHONE # DATE LAST SEEN

FAMILY DENTIST: (full name) PHONE # DATE LAST SEEN

		YES	NO
1.	Is your child presently under the care of a physician for any medical problem? What?_____	☐	☐
2.	Is your child adopted?	☐	☐
3.	Was your child premature? How many weeks?_____	☐	☐
4.	Did your child have a history of health problems at birth or during initial years? If yes, explain._____	☐	☐
5.	Is your child currently taking any medication? What?_____	☐	☐
6.	Has your child had a history of taking medications frequently?	☐	☐
7.	Has your child ever been hospitalized or had surgery? What?_____	☐	☐
8.	Is your child allergic to any food, medicine, other? What?_____	☐	☐
9.	Has any member of the family had a problem with a general anesthetic?	☐	☐

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO.

Y	N		Y	N		Y	N	
☐	☐	AIDS - HIV	☐	☐	Congenital Heart Disease	☐	☐	Hepatitis or Liver Disease
☐	☐	Anemia	☐	☐	Convulsions/Seizures	☐	☐	Hyperactivity/ADD
☐	☐	Asthma	☐	☐	Developmentally Delayed	☐	☐	Kidney Disease
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Leukemia
☐	☐	Bladder Conditions	☐	☐	Ear Stuffiness, Itching or Noises	☐	☐	Mental Retardation
☐	☐	Blood Transfusions	☐	☐	Emotional Disturbance	☐	☐	Nutritional Deficiency
☐	☐	Birth Defects	☐	☐	Epilepsy	☐	☐	Oral Ulcers
☐	☐	Bone or Joint Problems	☐	☐	Eye Problem	☐	☐	Orthopedic Problems
☐	☐	Brain Injury	☐	☐	Excessive Bleeding Problem	☐	☐	Premature Birth
☐	☐	Bruising Easily	☐	☐	Excessive Gagging	☐	☐	Rheumatic Fever
☐	☐	Cancer or Malignancies	☐	☐	Fainting or Dizziness	☐	☐	Scoliosis
☐	☐	Cerebral Palsy	☐	☐	Growth & Development Problems	☐	☐	TMJ Syndrome
☐	☐	Child Abuse	☐	☐	Headaches	☐	☐	Tuberculosis
☐	☐	Chronic Adenoid/Tonsil Infection	☐	☐	Hearing/Speech Problems	☐	☐	Other
☐	☐	Chronic Ear Infections	☐	☐	Heart Murmur			
☐	☐	Cleft Lip/Palate	☐	☐	Hemophilia			

DENTAL HISTORY

	YES	NO
Have tonsils and adenoids been removed? What age? _____	☐	☐
Have there been any injuries to the face, mouth or teeth? Treated by? _____	☐	☐
Has the patient ever sucked a thumb or fingers? Until what age?_____		
Is the patient a mouth breather? While awake?_____ While asleep?_____	☐	☐
Have you ever been informed of missing or extra teeth?	☐	☐
Does the patient clench or grind their teeth? During the Day?_____ At Night?_____	☐	☐
Does the patient have pain, clicking or limited movement opening or closing the mouth? If yes, please explain: _____	☐	☐
Has an orthodontist been consulted previoulsly?	☐	☐
Has either parent had orthodontic treatment?	☐	☐
List any musical instruments played._____		
What is your chief concern?_____		

The permission of parent or guardian is necessary for dental treatment of a minor. I give the doctor permission to use such measures as deemed necessary in his professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (X-Rays), and other diagnostic aids. I have given an accurate report of my child's physician and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

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

Signature_____ Relationship to Child _____ Date _____