



ADULT HEALTH QUESTIONNAIRE

(Please Complete All Four Pages)

Date: ___/___/___

Patient Information

Last Name: _____ First Name: _____ MI: _____
Preferred Name: _____ Age: _____ Birthdate: _____ Gender: _____
Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Whom may we thank for referring you to our office? _____
Why are you seeking an orthodontic evaluation? _____
Has anyone in your family been treated in this office before? _____
Occupation: _____ E-mail: _____
Business Address: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

Emergency Contact

Last Name: _____ First Name: _____ MI: _____
Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

Medical History

Physician: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of last physical exam: _____ Patient's Height/Weight: _____
Please describe your present health: _____
 Excellent Good Fair Poor



Date: __/__/__

Patient Name: _____

Medical History

- Please describe your present health: Excellent Good Fair Poor
- Has your health changed in the last year? Yes No
If yes, please explain _____
- Are you presently under the care of a physician? Yes No
If yes, please explain _____
- Are you presently taking any form of medication? Yes No
If yes, please list _____
- Do you smoke or use tobacco products? Yes No
- Have you ever had an allergic reaction to any medication? Yes No
If yes, please list _____
- Have you ever had an allergic reaction to any food or other substance? Yes No
If yes, please list _____
- Have you ever been hospitalized? Yes No
If yes, please explain _____
- Have you begun menstruation? (If applicable) Yes No
If yes, at what age? (If applicable) _____
- Is there a possibility that you might be pregnant? (If applicable) Yes No
- Do you wear contact lenses? Yes No
- Have you been in contact with anyone at risk for the following (please check those that apply):
- Tuberculosis
 - Hepatitis
 - Herpes
 - AIDS

Do you have or have you ever had any of the following:

- | | | | |
|---------------------------|--|---------------------------|--|
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Episodes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures or Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis, Liver Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or Other Immune | |
| Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | System Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ear Problems/Hearing Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis/Joint Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hives/Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
- Rheumatic Fever or Rheumatic Heart Disease Yes No
- Damaged Heart Valves (Mitral Valve Prolapse, Artificial Heart valve, Heart Murmur) Yes No
- If yes, do you need to be *premedicated* for dental procedures? Yes No
- Cardiovascular Disease (Heart Trouble, Heart Attack, Coronary Insufficiency, Coronary Occlusion Arteriosclerosis, Stroke) Yes No



Date: ___/___/___

Patient Name: _____

Dental History

Dentist: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of last dental visit: ___/___/___

Have you previously consulted an orthodontist? Yes No

If yes, when? _____

Have you ever had any orthodontic treatment? Yes No

If yes, when? _____

Were you satisfied with the treatment result? Yes No

Were any extractions performed? Yes No

If yes, how long ago and for what reason? _____

Is there a family history of missing teeth? Yes No

If yes, please describe _____

Do your gums bleed when you brush your teeth? Yes No

Is any part of your mouth sensitive to pressure? Yes No

Is any part of your mouth sensitive to temperature? Yes No

Have you ever had a thumb/finger sucking habit? Yes No

If yes, has the habit stopped? _____ When? _____

Do you breathe predominantly through your mouth? Yes No

Have you had tonsils/adenoids removed? Yes No

Do you snore? Yes No

Do you have or are you being treated for sleep apnea? Yes No

Do you clench or grind your teeth during the day? Yes No

Have you been made aware of clenching or grinding your teeth during sleep? Yes No

Do you have, or have you ever had, pain in your jaw joint(s) or sides of your face? Yes No

Have you ever had any clicking or popping in your jaw joint(s)? Yes No

Have you ever had any difficulty opening your mouth? Yes No

Have you ever experienced pain when opening your mouth wide? Yes No

Have you ever had any injury to your jaw or face? Yes No

If yes, please describe _____

Have you ever had any injury to your teeth? Yes No

If yes, please describe _____

Do you have any relatives that have been treated with orthognathic/jaw surgery? Yes No

If yes, please describe _____

Are you involved in any contact sports that require a mouthguard? Yes No

If yes, please describe _____



Date: __/__/__

Patient Name: _____

Responsible Party Information

Individual Responsible for Account: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Dental Insurance Information (No Medical Insurance Info Needed)

Primary Insured's Name: _____

Subscriber ID: _____

Insurance Company: _____

Group No.: _____ Policy: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Orthodontic coverage*: \$ _____ Lifetime Max Annual

Do you have dual coverage? Yes No

If Yes:

Secondary Insured's Name: _____

Subscriber ID: _____

Insurance Company: _____

Group No.: _____ Policy: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Orthodontic coverage*: \$ _____ Lifetime Max Annual

*To determine your policy's orthodontic coverage, terms, deductibles and claim payment policies, contact your insurance company before the exam and indicate the amount of coverage in the provided space.

Signature: _____

Relationship to Patient: _____

Date: _____

CONCORD ORTHODONTICS

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