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Date: __/__/__

ADULT HEALTH QUESTIONNAIRE

(Please Complete All Four Pages)

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 _____
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	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting Episodes	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No	Seizures or Epilepsy	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hepatitis, Liver Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	HIV Infection	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	AIDS or Other Immune System Disorder	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No			
Ear Problems/Hearing Loss	☐ Yes	☐ No	Arthritis/Joint Disorders	☐ Yes	☐ No
Hives/Skin Rash	☐ Yes	☐ 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: _____