ADULT ORTHODONTIC QUESTIONNAIRE

Patient's Name	Name Preferred	Male Female		
Primary Tele# Cell	Birthdate	Patient's Age		
Address Other	City Sta			
E-mail Address_				
	Shouse			
Vour Employer	Spouse			
Your Employer	Spouse's Employer			
Position	Position	Work		
Work Tele# Work	Work Tele#	——————————————————————————————————————		
Financially Responsible Party				
Name(mal	e / female) Relationship			
Address	City Stat	e Zip		
Phone#(cell / home / office) Driver's Lic#				
Direct 3 Elem	Social Security#			
Who is your dentist? When was your last dental cleaning?				
How long have you lived in this area? How did you hear about us? What is the purpose of today's visit or your chief concern for treatment?				
what is the purpose of today's visit of your effer ec	oncern for treatment?			
Are there problems with your health now? Yes No				
Recently, have you been treated by a physician?		Yes No Yes No		
Recently, have you taken medication or diet pills? Yes				
Have you ever consulted an orthodontist ? Yes No Have you ever received orthodontic treatment? Yes No				
Have other family marsh and have treatment?		Yes No		
Have other family members been treated by this practice? Yes No				
Please place an "X" if the patient has now or has ever had the following:				
Heart defect, trouble, abnormality	Soreness in jaws or	teeth		
Sensitive Gag Reflex	Popping or noises in	n jaw joints		
Emotional or stress related problems Ringing or buzzing noise				
Latex or Nickel Allergy	Difficulty opening of	Difficulty opening or closing		
Hepatitis or liver problems	Locking jaws open or closed			
Convulsions or seizures	Frequent earaches			
Fainting spells	Frequent headaches			
Nervous condition	Frequent ear infecti	ons		
Excessive bleeding	Tongue thrusting			
Gum disease	Mouthbreathing or noisy sleeping			
Shoulder or neck pains	Asthma, allergies or	hay fever (circle)		
The information above is correct and the insurance is	nformation is complete.			
Patient's Signature	Date			

INSURANCE INFORMATION

Please fill out information for each dental plan that the patient is covered under.

1.	Dental Insurance Company	
	Toll Free Phone #	
		Relation to Patient_
	Subscriber's Social Security #	
	Subscriber's Date of Birth	
	Employer	
	Plan #	
	Group #	
	Claim's Address	
,	Dental Insurance Company	
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	Toll Free Phone #	Dolation to Dotion
	Subscriber's Social Socurity #	Relation to Patient
	Subscriber's Social Security #	
	Subscriber's Date of Birth	
	Employer	
	Plan #	
	Group #	
	Claim's Address	
3.	Dental Insurance Company	
	Toll Free Phone #	
		Relation to Patient
	Subscriber's Social Security #	
	Subscriber's Date of Birth	
	Employer	
	Plan #	
	Group #	
	Claim's Address	