1. Complete the following questionnaire for the PATIENT

PATIENT First Name: _____ Middle Initials: _____ PATIENT Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male ○ Other Preferred Pronouns: _____

Marital Status: ○ Single ○ Married Street Address: _____ Apt./Unit #: _____ City: _____

State: _____ Zip Code: _____ Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. General Dentist Information:

Dentist Name: _____ Dental visit in last 6 months?: ○ Yes ○ No Any scheduled treatments? _____

3. Check if the patient has had any of the following (check all that apply). If checked "Yes" please explain below.

- ☐ Anemia
- ☐ Blood disorder
- ☐ Bleeding abnormality
- ☐ Tumor or growth
- ☐ Cancer treatment
- ☐ Radiation treatment
- ☐ Diabetes/ Hypoglycemia
- ☐ Endocrine/ Thyroid problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Bone disorder
- ☐ Joint replacement
- ☐ Rheumatoid arthritis
- ☐ Asthma/ COPD
- ☐ Epilepsy
- ☐ Convulsions/ Seizures
- ☐ Fainting/ Dizziness
- ☐ Headaches/ Migraines
- ☐ GERD/ Acid Reflux
- ☐ HIV/ AIDS
- ☐ Herpes
- ☐ Hepatitis B or C
- ☐ Attention deficit disorder
- ☐ Nervous disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric treatment
- ☐ Tobacco/ Vape/ Nicotine use
- ☐ Recreational drug use
- ☐ Current pregnancy

Please add details, and approximate age when condition occurred if not current, for any yes answers above:

_____

4. Indicate any history of (check all that apply); if checked "Yes", please explain.

- ☐ Thumb/ Finger sucking
- ☐ Nail biting
- ☐ Tongue and/or swallowing problems
- ☐ Speech problems
- ☐ Mouth breathing
- ☐ Tonsils and adenoids removed
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Grinding and/or clenching of teeth
- ☐ Jaw Pain
- ☐ Clicking or popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ History of wearing a mouthguard at night
- ☐ Loose teeth or broken fillings
- ☐ Crowns/ Bridges
- ☐ Root canals
- ☐ Bleeding gums
- ☐ History of Periodontal disease
- ☐ History of Periodontal treatment
- ☐ Mouth sores
- ☐ Cold sores
- ☐ Injury to face or teeth
- ☐ Sensitivity when biting
- ☐ Cold, hot, or sweets sensitivity
- ☐ Food collection between certain teeth
- ☐ Missing teeth
- ☐ Extra teeth

Other/Details:

_____

5. For patients under age 18, has patient reached puberty?

○ Yes ○ No

If yes (for patients under age 18), when/ what age?

_____

6. Please list any food, drug, or contact allergies:

	Allergy
1	

7. List all current medications and the correlating diagnosis:

	Medication	Diagnosis
1		

8. Any serious illnesses, hospitalizations, or other health conditions not listed elsewhere on this form? If yes, please describe.

_____

9. Is there anything else you would like us to know about your (or your child's) medical or dental health?:

_____

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

_____ _____

Signature Date