austin orthodontic arts

Date .....

Please FULLY complete the following health questionnaire.

Patient information

Patient name ..... (LAST) ..... (FIRST) ..... (MIDDLE) ..... (NICKNAME)

Address ..... (STREET) ..... (CITY) ..... (STATE) ..... (ZIP)

Home phone ..... Birth date ..... Social security # .....

If patient is a minor, give parent's/guardian's name .....

Family dentist ..... When last seen .....

Is any dental work pending? ..... Please describe .....

Whom may we thank for referring you to our office? .....

Please rank order the following items in order of your priority (1=most important, 4=least important)

..... **Cost of treatment**

..... **Quality of orthodontic result**

..... **Esthetic treatment options**

..... **Length of treatment**

Responsible party information

Name ..... (LAST) ..... (FIRST) ..... (MIDDLE) ..... (NICKNAME)

Email address ..... Marital status .....

Residence ..... (STREET) ..... (CITY) ..... (STATE) ..... (ZIP)

Mailing address ..... (STREET) ..... (CITY) ..... (STATE) ..... (ZIP)

How long at this address? ..... Home phone ..... Work phone .....

Previous address (if less than 3 years) ..... (STREET) ..... (CITY) ..... (STATE) ..... (ZIP)

Social security # ..... Birth date ..... Relationship to patient .....

Employer ..... Occupation ..... # Years employed .....

continued

Please FULLY complete the following health questionnaire.

Responsible party information, continued

Spouse's name ..... Relationship to patient .....
LAST FIRST MIDDLE

Employer ..... Occupation ..... # Years employed .....

Social security # ..... Birth date ..... Work phone .....

Dental insurance information

Insured's name ..... Insured's member ID# .....

Insurance company ..... Group # ..... Phone .....

Insurance company address .....

Do you have dual coverage? ☐ yes ☐ no If yes, please complete the following:

Insured's name ..... Insured's member ID# .....

Insurance company ..... Group # ..... Phone .....

Insurance company address .....

Insured's employer .....

Emergency information

Emergency contact .....

Complete address .....

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

Signature (parent's signature if minor) ..... **Updates** (date & initial) .....
(to be signed in the office)

Health status

Main concerns regarding the jaws and teeth .....

Patient's current **physical** health .....

Patient's current **mental** health .....

All **current medications** taken by patient .....

Please FULLY complete the following health questionnaire.

Medical history *(Please provide explanation for any "yes" answers)*

☐ yes ☐ no **Blood disorders** (prolonged bleeding, anemia, other)? .....

☐ yes ☐ no **Circulatory problems** (high blood pressure, heart murmur, antibiotic premedication, other)? .....

☐ yes ☐ no **Immune problems** (auto immune, diabetes, AIDS, other)? .....

☐ yes ☐ no **Airway problems** (mouth breathing, snoring, sleep apnea, asthma, tonsilectomy, other)? .....

☐ yes ☐ no **Allergies** (latex, food, drug, nickel, other)? .....

☐ yes ☐ no **Communicable disease** (HIV, hepatitis, tuberculosis, other)? .....

Dental history *(Please provide explanation for any "yes" answers)*

☐ yes ☐ no **Significant injury** to the teeth or jaws? .....

☐ yes ☐ no **Grind/clench** the teeth? .....

☐ yes ☐ no **Difficulty chewing?** .....

☐ yes ☐ no **Pain/clicking** in the jaw joints? .....

☐ yes ☐ no Treatment for a **TMJ disorder?** .....

Orthodontic history *(Please provide explanation for any "yes" answers)*

☐ yes ☐ no **Previous orthodontic treatment?** .....

☐ yes ☐ no **Concerns** about orthodontic treatment? .....

☐ yes ☐ no **Habits** related to the teeth (nail biting, finger habit, smoking, tobacco use, other)? .....

☐ yes ☐ no **Speech disorders/speech therapy?** .....

Signature ..... **Print name** ..... **Date** .....
(to be signed in the office)

Any additional information that the doctor might find helpful

SUBMIT

If the submit button does not work for you, please print out the completed form and bring to Austin Orthodontic Arts at the time of your appointment.

PRINT