

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 LAST FIRST MIDDLE Relationship to patient
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

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.