



## New Patient Questionnaire

Thank you for selecting Ann Arbor Orthodontics, where we are committed to providing you with personalized service and care beyond your expectations. At your first visit you will receive a comprehensive evaluation of your orthodontic concerns. If you are ready for treatment and would like to have diagnostic records taken the same day to avoid a separate appointment, there will be a charge for the diagnostic records.

We have enclosed this questionnaire in order to help us with your diagnosis and treatment planning. *Please complete this questionnaire and bring it with you;* thank you.

### Please provide us with the following information on this patient:

**Patient's** Last Name: \_\_\_\_\_, 1st \_\_\_\_\_ MI \_\_\_\_\_, Nickname: \_\_\_\_\_ Sex:  M  F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ ZIP \_\_\_\_\_ Home Phone: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_  
 \_\_\_\_\_  
 Years lived at above address: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 School/Employer: \_\_\_\_\_ Grade/Dept. \_\_\_\_\_ Years with this Employer (if adult): \_\_\_\_\_  
 Marital Status (or parent's marital status if a child):  Married  Separated  Widowed  Divorced  Single  
 E-mail address: \_\_\_\_\_ Did  
 someone refer you to our office? \_\_\_\_\_

**Father/Husband:** \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Years lived at above address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Years with this Employer: \_\_\_\_\_ Dept: \_\_\_\_\_ OK to contact at office?  Yes  No

**Mother/Wife:** \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Years lived at above address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Years with this Employer: \_\_\_\_\_ Dept: \_\_\_\_\_ OK to contact at office?  Yes  No

**Financially Responsible Person** (check off who will be paying on this account):  Patient  Father  Mother  Other (complete below ONLY if  Other)

Other Name: \_\_\_\_\_ Relation to Pt.: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Years lived at above address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Years with this Employer: \_\_\_\_\_ Dept: \_\_\_\_\_ OK to contact at office?  Yes  No

**Insurance:** Name of Insured:  Patient  Father  Mother  Guarantor \_\_\_\_\_

**Dental Insurance?**  No  
 INS. Co.: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_ Covers Orthodontic Treatment?  Yes  No  ?  
 INS. Co. Phone: \_\_\_\_\_ Address: \_\_\_\_\_ Guarantor's Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**OTHER Dental Insurance?**  No  
 Name of Insured: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Insured's Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 INS. Co.: \_\_\_\_\_ Group Plan #: \_\_\_\_\_  
 INS. Co. Phone: \_\_\_\_\_ Address: \_\_\_\_\_

**In case we can't reach you,** whom can we contact: Person's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Person's Address: \_\_\_\_\_

# Medical History

(Please answer all questions)

Name of Family Physician: \_\_\_\_\_ Date of last visit to physician \_\_\_\_\_  
 Are there any medical specialists you see regularly? \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Date of last *complete physical exam*: \_\_\_\_\_ Examining doctor: \_\_\_\_\_  
 Pharmacy: Name \_\_\_\_\_ Phone: \_\_\_\_\_

- Has this patient been advised by a physician that they require an *antibiotic prior to dental treatment*?  No If  Yes, Antibiotic: \_\_\_\_\_ **Pre-Medicate?**  No If  Yes, Rx: \_\_\_\_\_
- How is antibiotic given? \_\_\_\_\_
- This patient's general health at this time is: .....  Good,  Fair,  Poor Comment? \_\_\_\_\_
- Is this patient presently under the care of a physician? .....  No, If  Yes, For what? \_\_\_\_\_
- Is this patient presently taking medications? .....  No, If  Yes, which medications: \_\_\_\_\_
- Has this patient had tonsils or adenoids removed? .....  No, If Yes,  Tonsils (on date \_\_\_\_\_)  Adenoids (on date \_\_\_\_\_)
- Does this patient have a *Chronic Illness*? .....  No, If  Yes, Comment? \_\_\_\_\_
- Is this patient allergic to antibiotics (penicillin, etc)? .....  No, If  Yes, which medications: \_\_\_\_\_
- Does this patient have anesthetic reactions? .....  No, If  Yes,  Local  General: \_\_\_\_\_
- Is this patient allergic to anything else? .....  No, If  Yes, what?  Sulfa Drugs  Aspirin  Ibuprofen  Environmental  Metals  Plastics  Latex Comments: \_\_\_\_\_ **Allergy Alert?**  No \_\_\_\_\_

■ **Does this patient now have, or ever had any of the following problems?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Rheumatic Fever          | <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis (type? _____)                | <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes                          |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Endocarditis             | <input type="checkbox"/> No <input type="checkbox"/> Yes Aids or HIV Positive                   | <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy                          |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Condition          | <input type="checkbox"/> No <input type="checkbox"/> Yes Tuberculosis                           | <input type="checkbox"/> No <input type="checkbox"/> Yes Lived with tuberculin person      |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory Lung Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes Tonsillitis                            | <input type="checkbox"/> No <input type="checkbox"/> Yes Earaches                          |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Asthma                   | <input type="checkbox"/> No <input type="checkbox"/> Yes Mitral Valve Prolapse                  | <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Disorders/Bleeding Problems |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Congenital Heart Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes Herpes (Oral Cold Sores)               | <input type="checkbox"/> No <input type="checkbox"/> Yes Liver Disease                     |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Artificial Heart Valve   | <input type="checkbox"/> No <input type="checkbox"/> Yes Inflammatory Rheumatism                | <input type="checkbox"/> No <input type="checkbox"/> Yes Emotional Problems (note below)   |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis                | <input type="checkbox"/> No <input type="checkbox"/> Yes X-Ray (radiation) cancer therapy _____ |  |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Murmur             | <input type="checkbox"/> No <input type="checkbox"/> Yes Glaucoma                               |  |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Pressure Problems  | <input type="checkbox"/> No <input type="checkbox"/> Yes Fainting Spells                        | <b>Medical Alert?</b> <input type="checkbox"/> No _____                                    |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Kidney Trouble           | <input type="checkbox"/> No <input type="checkbox"/> Yes Smokes                                 |  |

Please comment on  Yes responses: \_\_\_\_\_

- Does this patient have any other medical problems not listed?  No, If  Yes, Comment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patient's Growth History:** What is this patient's height? \_\_\_Ft. \_\_\_ In  
 Child's present age: \_\_\_years, \_\_\_months  
 Is child adopted?  No  Yes  
 Any recent signs of increased growth?  No  Yes

If a *BOY*, has his voice changed?  No  Yes  
 If a *GIRL*, has she started menstruation?  No  Yes  
*MOTHER'S* present height: \_\_\_Ft. \_\_\_In.  
*FATHER'S* present height: \_\_\_Ft. \_\_\_In.

**Additional Growth?**  
 No  Yes  
 Possibly

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medical History Reviewed: Dr.'s Initials: \_\_\_\_\_

# Dental History

Name of Family Dentist: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

How many times a day do you BRUSH? 1 2 3+

How many times a day do you FLOSS? 0 1 2+

- Has this patient been examined by another orthodontist? No, If Yes, Date: \_\_\_\_\_, Name of orthodontist \_\_\_\_\_
  - Has this patient ever had orthodontic treatment (braces)? No, If Yes, Date: \_\_\_\_\_, Name of orthodontist \_\_\_\_\_
  - Has this patient been treated for jaw joint (TMJ) problems? No, If Yes, Date: \_\_\_\_\_, Name of dentist \_\_\_\_\_
  - Has this patient been treated for gum disease? No, If Yes, What kind of treatment? \_\_\_\_\_
  - Has this patient had a root canal treatment? No, If Yes, Which teeth? \_\_\_\_\_
  - Has this patient had other dental specialist treatment? No, If Yes, What? \_\_\_\_\_
  - Does this patient have any oral habits? No, If Yes,
    - Thumb sucking Lip biting
    - Finger sucking Thrusting
    - Speech problems Mouth breathing
  
  - Does this patient have any TMJ (jaw joint) symptoms? No, If Yes,
    - Grinding Clenching
    - Jaw joint noises Headaches/Neckaches
    - Jaw joint pain Locking or difficulty moving jaws
    - Facial or ear pain Dental/facial trauma
    - Arthritis
- Comments \_\_\_\_\_
- Does this patient have any missing or extra permanent teeth? No, If Yes, Comment: \_\_\_\_\_
  - Does this patient typically have bleeding gums? No, If Yes, Comment: \_\_\_\_\_
  - Does this patient have sores, lumps or irritated tissue in the mouth? No, If Yes, Comment: \_\_\_\_\_
  - Has this patient had any injuries to his/her teeth? No, If Yes, @ Age: \_\_\_\_\_ Chipped Broken Lost
  - Has this patient had any injuries to his/her face or jaws or mouth? No, If Yes, @ Age: \_\_\_\_\_ Comment: \_\_\_\_\_
  - Are there any other comments about this patient's dental history? No, if Yes, Comment: \_\_\_\_\_

## Patient and Family Concerns:

- What are this patient's concerns about his or her teeth? Appearance of teeth Oral function Crowding/spacing Flared teeth
  - Other concerns or comments: \_\_\_\_\_
  - Is this patient anxious about having orthodontic treatment? No, If Yes, Comment: \_\_\_\_\_
- 
- Does the family dentist have any concerns about this patient's teeth? No, If Yes, Comment: \_\_\_\_\_
  - Do other family members have concerns about this patient's teeth? No, If Yes, Comment: \_\_\_\_\_

I the undersigned have completed this medical and dental health history and certify that the preceding information is true and correct. This practice cannot be held responsible for any problems arising out of inadequate information not disclosed here. If there are any future changes in this information, I will inform this practice of these changes.

Signature of *person filling out this history*: \_\_\_\_\_ Date completed/signed: \_\_\_\_\_

Signature of *TC* who reviewed this history: \_\_\_\_\_ Date reviewed/signed: \_\_\_\_\_

Signature of *DOCTOR* who reviewed history: \_\_\_\_\_ Date reviewed/signed: \_\_\_\_\_