

QUAD CITY ORTHODONTICS
PLEASE COMPLETE THE FOLLOWING PAGES

CHILD PATIENT

Name _____
Last First Middle Birth Date Age

Patient Living With Mother Father Both

Father's Name _____
Last Title (Dr. Mr. Rev.) First

Step Mother's Name _____
Last Title (Mrs. Ms. Miss Dr. Rev.) First

Address _____
Street City Zip Phone

Employer _____ Address _____

Work # _____ Cell # _____ Social Security # _____

Mother's Name _____
Last Title (Mrs. Ms. Miss Dr. Rev.) First

Step Father's Name _____
Last Title (Dr. Mr. Rev.) First

Address _____
Street City Zip Phone

Employer _____ Address _____

Work # _____ Cell # _____ Social Security # _____

Parent Marital Status Single Married Separated Divorced Widowed

If patient is a minor, who is responsible for the account? _____

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

ADULT PATIENT

Name _____
Last Title (Mrs. Ms. Miss Mr. Dr. Rev.) First Middle Birth Date Age

Address _____
Street City Zip Phone

Employer _____ Address _____

Work # _____ Cell # _____ Social Security # _____

Marital Status Single Married Separated Divorced Widowed

Spouse's Name _____ Spouse's Employer _____

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

ORTHODONTIC INSURANCE INFORMATION

PRIMARY

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS# / SIN _____

Name of Employer _____

Insurance Company _____ Group # _____ Insurance Phone# _____

Insurance Company Address _____
City State Zip

SECONDARY

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS# / SIN _____

Name of Employer _____

Insurance Company _____ Group # _____ Insurance Phone# _____

Insurance Company Address _____
City State Zip

HOBBIES / INTEREST _____

Would you like to receive e-mail confirmations, updates and office newsletters?

No Yes - e-mail address _____

MEDICAL HISTORY

Family Physician _____ Specialty _____

Additional Physician _____ Specialty _____

Height _____ Weight _____ Age _____ Date of last complete medical examination _____

Please circle YES or NO. If YES, please fill in details.

Yes No Do you have a current medical problem? What? _____

Yes No Do you have heart trouble or a heart murmur? _____

Yes No Have you had rheumatic fever? When? _____

Yes No Do you have high or low blood pressure? Is it controlled? _____

Yes No Have you had pains in the chest or shortness of breath? _____

Yes No Do your ankles ever swell? _____

Yes No Has your physician ever told you that you are anemic? _____

Yes No Have you ever had a stroke? When? _____

Yes No Have you ever had diabetes? How is it controlled? _____

Yes No Are you subject to fainting or dizziness? When? _____

Yes No Do you have headaches? How often? _____

Yes No Do you have any nervous disorder? How is it controlled? _____

Yes No Do you take tranquilizers or sedatives? How often? _____

Yes No Do you take aspirin? How often? _____

Yes No Are you allergic to any medication? What? _____

Yes No Have you been advised not to take any medication? What? _____

Yes No Do you have asthma or hay fever? How is it controlled? _____

Yes No Have you ever had tuberculosis? When? _____

Yes No Have you ever had infectious hepatitis? When? _____

Yes No Do you have arthritis? How is it controlled? _____

Yes No Have you ever had a tumor or cancer? How was it treated? _____

Yes No Have you had any major operations? What kind? _____

Yes No Have you had your tonsils or adenoids removed? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Are you taking any medication? Please list:

Taking _____ For _____ Taking _____ For _____

Taking _____ For _____ Taking _____ For _____

Taking _____ For _____ Taking _____ For _____

Yes No Have you gained or lost weight within the last year? How much? _____

Yes No Do you take more than one alcoholic drink per day? How many? _____

Yes No Do you use tobacco? How much? _____

Yes No Is your diet medically supervised? For what purpose? _____

Yes No Have you or any member of your family tested positive for AIDS or HIV? _____

Yes No For Women: Are you Pregnant? Expected delivery date _____

DENTAL HISTORY

Family Dentist _____ Other Dentist _____

Do you premedicate before dental appointments? _____

Date of last dental cleaning? _____

Have you ever seen an orthodontist before? _____ If so, when? _____

What is your immediate dental concern? _____

Please circle YES or NO. If YES, please fill in details.

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
What? _____

Yes No Have you had any teeth removed? _____

Yes No Do you have any growths or swellings in your mouth? How long have they existed? _____

Yes No Do you have any difficulty in swallowing? _____

Yes No Do your gums bleed when brushing your mouth? _____

Yes No Do you avoid brushing any part of your mouth? Why? _____

Yes No Have you ever been told you have pyorrhea? Why? _____

Yes No Is any part of your mouth sensitive to temperature, pressure or food or drink? What? _____

Yes No Do you have a burning sensation of your mouth? _____

Yes No Have you ever had a bad reaction to a dental anesthetic? When? _____

Yes No Does food catch between your teeth? _____

Yes No Do you have any pain or soreness around your eyes or ears or other parts of your face?
When? _____

Yes No Are you aware of clenching your teeth during your daytime hours? How often? _____

Yes No Have you ever been told you grind your teeth during sleep? How often? _____

Yes No Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

Yes No Do you have difficulty in opening your mouth widely? _____

Yes No Do you have an unpleasant taste or odor in your mouth? _____

Yes No Are you satisfied with your teeth and appearance? _____

Yes No Are you willing to wear braces if they are necessary to restore your good dental health? _____

Please use this space for any necessary explanations which may assist us in the proper diagnosis of any problems you may have.

I hereby state that I have truthfully to the best of my ability answered all the above questions.

Signature _____ Date _____

