Orthodontic Patient Questionnaire

Patient’s name: ___________________________ Date of Birth: ____________ Sex: Male or Female

DENTAL HISTORY

• Patient’s General or Pediatric Dentist: ___________________________ Phone: (______) ____________________

• Has another member of the family had orthodontic treatment? □ Yes □ No
  If yes, list their names: __________________________________________

• Has the patient had a previous orthodontic consultation? □ Yes □ No

• Has the patient ever had trauma/damage to teeth, jaws or gums? □ Yes □ No

• Does the patient brush his/her teeth: □ Often □ Occasionally □ Reluctantly

• Does/did the patient grind his/her teeth at night? □ Yes □ No

• Does/did the patient suck his/her thumb, finger or pacifier? □ Yes □ No
  If yes, what age was the habit discontinued? ______________________

• Is there any popping, clicking or locking of the jaw upon opening or closing? □ Yes □ No

MEDICAL HISTORY

• Family Physician: ___________________________ Phone: (______) ____________________

• Is the patient currently under a physician's care? □ Yes □ No
  If yes, please explain: __________________________________________

• Is the patient currently taking medication? □ Yes □ No
  If yes, please list: __________________________________________

• Is the patient allergic to any medications? □ Yes □ No
  If yes, please list: __________________________________________

• Does the patient have any other allergies? □ Yes □ No
  If yes, please list: __________________________________________

• Does the patient need to be premedicated with antibiotics for routine dental procedures? □ Yes □ No
  If yes, please specify and give reason for this need: ____________________________

• Has the patient ever been hospitalized? □ Yes □ No
  If yes, please explain: __________________________________________

• Female patients only: Are you pregnant? □ Yes □ No
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Patient’s Name: ___________________________ DOB: ___________________________

DOES THE PATIENT HAVE OR HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING:

Y / N AIDS/HIV+  Y / N Diabetes  Y / N Anemia
Y / N Kidney Disease  Y / N Oral Ulcers  Y / N Birth Defects
Y / N Lung Disease  Y / N Heart Condition  Y / N Rheumatic Fever
Y / N Previous Surgery  Y / N Psychological Therapy  Y / N Hepatitis
Y / N Hearing Problem  Y / N Injury to head  Y / N Epilepsy/Seizures/Fainting spells
Y / N Asthma  Y / N Bleeding Disorder  Y / N Speech Therapy
Y / N Cold Sores  Y / N Cerebral Palsy  Y / N Tonsils/Adenoid Surgery
Y / N Arthritis  Y / N Radiation/Cancer Therapy

• Does the patient have any disease, condition or problem not listed above?  □ Yes  □ No
If yes, please explain: ____________________________________________________________

PATIENT’S ATTITUDE TOWARD ORTHODONTIC TREATMENT (skip if an adult patient)

• Is there a dental problem causing self-esteem or social issues?  □ Yes  □ No
• Patient’s interest in having orthodontic treatment: □ Excited □ Willing if necessary □ Reluctant
• How would you describe your child (check any that apply):
  □ Calm  □ Nervous  □ Quiet  □ Shy  □ Outgoing  □ Afraid  □ Uncooperative  □ Cooperative  □ Confident
• To determine your child’s stage of growth: Height: _______ ft. _______ in. Weight: _______ lbs.
• Females: Has the patient started her menstruation?  □ Yes  □ No (If yes, what age? ______)
• Males: Has the patient yet undergone voice changes or facial hair growth?  □ Yes  □ No

PARENT/GUARDIAN INFORMATION (SKIP IF AN ADULT PATIENT)

Parent/Guardian: ___________________________ Relationship: ________ Occupation: ________________

Parent/Guardian: ___________________________ Relationship: ________ Occupation: ________________

Marital Status:  □ Married  □ Separated  □ Divorced  □ Single  □ Widowed

I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child’s medical status. I give consent for digital photos and x-rays to be taken for this patient.

Signature of parent/ guardian/adult patient completing form: ___________________________ Date: ____________

Printed name: ____________________________

Thank you for your help. We are excited to get to know you better!

13841 Hull Street Road, Suite 4, Midlothian, VA 23112
804.739.0963

Pediatric Dentistry and Orthodontics of Virginia

651 Southpark Boulevard
Colonial Heights, VA 23834
804.526.9815