EAST TENNESSEE ORTHODONTICS

(For Patients Over Age 18)

Today's Date _____

Patient Name _____ Prefer to be called _____ Sex

Address _____

City, State, Zip _____

Home Phone _____ Email _____

Occupation _____ Employed By _____

Spouse's Name _____ Work Phone _____

Occupation _____ Employed By _____

Who may we contact in case of emergency? _____ Phone _____

Family Dentist _____ Family Physician _____

In your opinion, what is your orthodontic problem? _____

_____

Who may we thank for recommending you for your appointment? _____

Person responsible for account _____

Social Security # _____ Birthdate _____ Age _____ Sex

Address _____

City, State, Zip _____

Do you have orthodontic insurance coverage? ☐ No ☐ Yes, Company _____

Group Number _____ Phone/Contact _____

Secondary Insurance Coverage _____

HEALTH QUESTIONNAIRE

Today's Date _____

Patient Name _____ Birthdate _____

Date of last dental visit or check-up _____

Have you ever had the following dental treatment?

- ☐ Orthodontics, Date _____ , by Dr._____
- ☐ Periodontal treatment (gum treatment)
- ☐ Mouthguard or splint therapy for jaw joint problems
- ☐ Jaw surgery to change your bite or to correct jaw joint

Do you have or have you had any of the following <u>oral</u> conditions?

- ☐ Clenching or grinding
- ☐ Jaw joint sounds or pain
- ☐ Jaw gets stuck open or closed
- ☐ Pain in jaw or face
- ☐ Pain when opening or closing mouth
- ☐ Pain around ear
- ☐ Bleeding gums
- ☐ Bad Breath
- ☐ Food wedging between teeth
- ☐ Injury or blow to the chin or jaw
- ☐ Dry Mouth
- ☐ Discolored teeth
- ☐ Sensitive Teeth
- ☐ Poorly functioning teeth
- ☐ Swelling or lumps in the mouth
- ☐ Mouth Breathing
- ☐ Oral habits (thumb sucking, etc)
- ☐ Tobacco use

Do you have or have you had any of the following <u>medical</u> conditions?

- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Sleep Apnea
- ☐ Arthritis (any type)
- ☐ Liver disease
- ☐ Hepatitis type C
- ☐ Yellow jaundice
- ☐ Chronic Pain Disorders
- ☐ Easy bruising
- ☐ Congenital heart lesions / murmur
- ☐ Anemia
- ☐ Kidney problems
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Ear problems
- ☐ Eye problems
- ☐ HIV positive
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Severe Headaches
- ☐ Dizziness or Fainting
- ☐ Convulsions or seizure
- ☐ Sinus problems
- ☐ Swallowing problems
- ☐ Speech problems

Are you currently under a physician's care? If yes, describe _____ ☐yes ☐no

Has patient ever been hospitalized or had any serious illness? If yes, describe _____ ☐yes ☐no

Does the patient have any drug allergies? If yes, list medications _____ ☐yes ☐no

Is the patient allergic to latex? ☐yes ☐no

Is the patient taking any medication? If yes, list medications _____ ☐yes ☐no

Have you ever taken Bisphosphonates to treat osteoporosis or other bone related diseases ☐yes ☐no

<u>Female patients</u> – could patient possibly be pregnant at the present time? ☐yes ☐no

Patient signature _____ **Date**_____

Notes:

_____

_____

_____