NEW PATIENT INFORMATION QUESTIONNAIRE

(Adult)

[**IMPORTANT**: Please fill out this patient questionnaire and bring your insurance card/form (with the employee's sections filled out and signed) to your consultation appointment at our office.]

Please Print Date:______________________________________

NAME: Last ____ First _______________________ Middle ______________

Nickname (if any) ____ Birthdate ___________________________

Home Phone (_______) ____________________________ Sex ______ Height ________ Weight _______ Age ______

Address ____ City _____________________Zip__________

Marital Status: ☐ Married ☐ Single E-Mail Address: ____
☐ Divorced ☐ Widowed ☐ Separated

FINANCIALLY RESPONSIBLE PERSON:

Name ____
Last First MI

____
Street Address

____
City Zip

____
Previous Address City Zip
(If less than 3 years at present address)

____
Employer

____
Spouse's First Name MI Last

____
Relationship to Patient

(_________) ______________________________________
Home Phone

(_________)______________________________________
Cell or Work Phone

_______-_______-_________ _____________ ________
Social Sec. No. Birthdate Age

____
Driver's Lic. No.

______________________ ______________________
Occupation # Years Employed

______________________ (_____)______________
Spouse's Employer Daytime Phone

LET'S GET ACQUAINTED:

What's your favorite... Color? ______________________________________ Sport? __________________________________

What do you like to do in your spare time (hobbies, sports, recreation)? ____

____

Other stuff you'd like to tell us about yourself: ____

DENTIST: Name ____ Address _______________________________________

Phone (_____) ___________________________________ Date Last Checked ____________________________

REFERRAL: Whom may we thank for referring you to our office? ____

Is anyone in your family having or had orthodontic work done in this office? (Specify) __________________

FAMILY: To best serve our families and community, we offer a family program as a courtesy to our patients. We see the young children every 6 months at no charge. This program allows us to keep a record and monitor the growth and development of each child. Please list sons and daughters:

Name	Birthdate	Age	Does he/she have orthodontic problems?	Has he/she been treated for orthodontics?
____________________________	___________	____	_______	_________________
____________________________	___________	____	_______	_________________
____________________________	___________	____	_______	_________________

(Continued)

INSURANCE INFORMATION:

Insured's Name ______________________ Insured's Social Security Number ______________________

Insurance Company ______________________ Group No. __________ Local No. __________

Insurance Co. Address ______________________ Insured's Employer ______________________

Do you have dual coverage? Yes___ No___ If yes:

Insured's Name ______________________ Insured's Social Security Number ______________________

Insurance Company ______________________ Group No. __________ Local No. __________

Insurance Co. Address ______________________ Insured's Employer ______________________

DENTAL HISTORY

Yes	No	
☐	☐	Have there been any injuries to the face, mouth or teeth? If yes, explain: ______________________
☐	☐	Have you undergone speech therapy?
☐	☐	Are you aware of any missing permanent teeth? If so, which ones? ______________________
☐	☐	Have you received any previous orthodontic treatment?

What is your chief concern regarding your teeth: ______________________

Do you have or have you had any of the following:

Yes	No	
☐	☐	Teeth sensitive to cold, heat, sweets or pressure
☐	☐	Bleeding gums. If so, how long?
☐	☐	Food impaction
☐	☐	Burning of Tongue
☐	☐	Swelling or lumps in mouth
☐	☐	Frequent blisters on lips or mouth
☐	☐	Pain around ear
☐	☐	Unusual sounds in ear while eating
☐	☐	Bad breath
☐	☐	Unpleasant taste
☐	☐	Unfavorable dental experience
☐	☐	Complications from extractions
☐	☐	Periodontal treatment

Do you regularly:

Yes	No	
☐	☐	Brush ____________ times a day
☐	☐	Floss daily
☐	☐	Use mouthwash

MEDICAL HISTORY

Your physician ______________________ Phone (_____) ______________________ Address: ______________________

Any medical or physical disorders? ______________________

Are you in good health? ______________________ Taking any medication now? ______________________

Are you under a physician's care now? __________ If so, please give reasons for treatment: ______________________

Do you experience or have you experienced:

Yes	No	
☐	☐	Chest pain (angina)
☐	☐	Swollen ankles
☐	☐	Shortness of breath
☐	☐	Recent weight loss, fever, night sweats
☐	☐	Persistent cough, coughing up blood
☐	☐	Bleeding problems, bruising easily
☐	☐	Sinus problems
☐	☐	Difficulty swallowing
☐	☐	Diarrhea, constipation, blood in stools
☐	☐	Frequent vomiting, nausea
☐	☐	Difficulty urinating, blood in urine
☐	☐	Dizziness
☐	☐	Ringing in the ears
☐	☐	Headaches
☐	☐	Fainting spells
☐	☐	Pregnancy or nursing (females only)
☐	☐	Blurred vision
☐	☐	Seizures
☐	☐	Excessive thirst
☐	☐	Frequent urination
☐	☐	Dry mouth
☐	☐	Jaundice
☐	☐	Joint pain, stiffness

Do you have or have you had:

Yes	No	
☐	☐	Heart disease, Heart attack
☐	☐	Heart murmurs
☐	☐	Rheumatic fever
☐	☐	Stroke, hardening of arteries
☐	☐	High blood pressure
☐	☐	TB, emphysema, other lung diseases
☐	☐	Hepatitis, other liver disease
☐	☐	Nervous disorders
☐	☐	Stomach problems, ulcers
☐	☐	Allergies to drugs, food, medications List: ______________________
☐	☐	Allergies to latex gloves
☐	☐	Family history of diabetes, heart problems, tumors
☐	☐	AIDS or ARC
☐	☐	Tumors, cancer
☐	☐	Arthritis, Rheumatism
☐	☐	Asthma
☐	☐	Eye disease
☐	☐	Skin diseases
☐	☐	Anemia
☐	☐	VD (syphilis or gonorrhea)
☐	☐	Herpes
☐	☐	Kidney, bladder disease
☐	☐	Thyroid, adrenal disease
☐	☐	Taken Fen-Phen or appetite suppressants

Do you have or have you had:

Yes	No	
☐	☐	Psychiatric care
☐	☐	Radiation treatments
☐	☐	Chemotherapy
☐	☐	Prosthetic heart valve
☐	☐	Artificial joint
☐	☐	Hospitalization
☐	☐	Blood transfusions
☐	☐	Surgeries
☐	☐	Pacemaker
☐	☐	Contact lenses

Do you take:

Yes	No	
☐	☐	Drug, medicines (including aspirin and birth control pills) List: ______________________
☐	☐	Recreational drugs
☐	☐	Tobacco in any form
☐	☐	Alcohol

(Continued)

Do you have or have you had any other diseases or medical problems NOT listed on this form? ___________ If yes, explain: ___________________________

____

Any other information we should know about your health? ____

____

By signing this form, you acknowledge that the office of Abari Orthodontics has permission to examine you and that the information provided by you is true and accurate. You agree to inform us of any change in your health and/or medication. As a patient in our practice, we share your medical/dental information with your dentist and other dental professionals, insurance company and other sources in the course of your treatment. I hereby authorize payments directly to this office of the group insurance benefits otherwise payable to me.

Date _________________________________ *Signature* ____

Date _________________________________ *Signature* ____

Additionally, since we will be making financial arrangements regarding payment of this account and extending credit, where appropriate, you give us permission to obtain credit bureau reports.

Date _________________________________ *Signature* ____

Date _________________________________ *Signature* ____

Our Mission Statement

It is our desire to provide a unique professional experience for all who encounter our office. To that end, we commit to treating with love and care our patients, parents, each other, and anyone else who comes to our office, placing their concerns before our own. We commit to providing excellence in our orthodontic treatment and to our goal of a balanced face, healthy jaw joints and beautiful smiles. Our primary concern is about relationships, not just about treatment of teeth.

Health History Review:

Year 2
Changes in Health: ____

Date:_______________ Patient's Signature: ____ Doctor's Signature: ____

Year 3
Changes in Health: ____

Date:_______________ Patient's Signature: ____ Doctor's Signature: ____

Year 4
Changes in Health: ____

Date:_______________ Patient's Signature: ____ Doctor's Signature: ____