

**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  Divorced  Widowed  Separated E-Mail Address: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PERSON:**

Name \_\_\_\_\_  
Last First MI

Relationship to Patient  
(\_\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_

Home Phone  
(\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Cell or Work Phone  
\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

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

Social Sec. No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Driver's Lic. No. \_\_\_\_\_

**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. \_\_\_\_\_

**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:*

- |  |  |   |
|--|--|---|
| <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure</li> <li><input type="checkbox"/> <input type="checkbox"/> Bleeding gums. If so, how long?</li> <li><input type="checkbox"/> <input type="checkbox"/> Food impaction</li> <li><input type="checkbox"/> <input type="checkbox"/> Burning of Tongue</li> <li><input type="checkbox"/> <input type="checkbox"/> Swelling or lumps in mouth</li> <li><input type="checkbox"/> <input type="checkbox"/> Frequent blisters on lips or mouth</li> </ul> | <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Pain around ear</li> <li><input type="checkbox"/> <input type="checkbox"/> Unusual sounds in ear while eating</li> <li><input type="checkbox"/> <input type="checkbox"/> Bad breath</li> <li><input type="checkbox"/> <input type="checkbox"/> Unpleasant taste</li> <li><input type="checkbox"/> <input type="checkbox"/> Unfavorable dental experience</li> <li><input type="checkbox"/> <input type="checkbox"/> Complications from extractions</li> <li><input type="checkbox"/> <input type="checkbox"/> Periodontal treatment</li> </ul> | <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Bone loss</li> </ul> <p><i>Do you regularly:</i></p> <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Brush _____ times a day</li> <li><input type="checkbox"/> <input type="checkbox"/> Floss daily</li> <li><input type="checkbox"/> <input type="checkbox"/> Use mouthwash</li> </ul> |
|--|--|---|

**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:*

- |  |  |   |
|--|--|---|
| <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Chest pain (angina)</li> <li><input type="checkbox"/> <input type="checkbox"/> Swollen ankles</li> <li><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> <input type="checkbox"/> Recent weight loss, fever, night sweats</li> <li><input type="checkbox"/> <input type="checkbox"/> Persistent cough, coughing up blood</li> <li><input type="checkbox"/> <input type="checkbox"/> Bleeding problems, bruising easily</li> <li><input type="checkbox"/> <input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing</li> </ul> | <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Diarrhea, constipation, blood in stools</li> <li><input type="checkbox"/> <input type="checkbox"/> Frequent vomiting, nausea</li> <li><input type="checkbox"/> <input type="checkbox"/> Difficulty urinating, blood in urine</li> <li><input type="checkbox"/> <input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> <input type="checkbox"/> Ringing in the ears</li> <li><input type="checkbox"/> <input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> <input type="checkbox"/> Fainting spells</li> <li><input type="checkbox"/> <input type="checkbox"/> Pregnancy or nursing (females only)</li> </ul> | <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Blurred vision</li> <li><input type="checkbox"/> <input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> <input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> <input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> <input type="checkbox"/> Dry mouth</li> <li><input type="checkbox"/> <input type="checkbox"/> Jaundice</li> <li><input type="checkbox"/> <input type="checkbox"/> Joint pain, stiffness</li> </ul> |
|--|--|---|

*Do you have or have you had:*

- |   |   |   |
|---|---|---|
| <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Heart disease, Heart attack</li> <li><input type="checkbox"/> <input type="checkbox"/> Heart murmurs</li> <li><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</li> <li><input type="checkbox"/> <input type="checkbox"/> Stroke, hardening of arteries</li> <li><input type="checkbox"/> <input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> <input type="checkbox"/> TB, emphysema, other lung diseases</li> <li><input type="checkbox"/> <input type="checkbox"/> Hepatitis, other liver disease</li> <li><input type="checkbox"/> <input type="checkbox"/> Nervous disorders</li> </ul> | <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Stomach problems, ulcers</li> <li><input type="checkbox"/> <input type="checkbox"/> Allergies to drugs, food, medications<br/>List: _____</li> <li><input type="checkbox"/> <input type="checkbox"/> Allergies to latex gloves</li> <li><input type="checkbox"/> <input type="checkbox"/> Family history of diabetes, heart problems, tumors</li> <li><input type="checkbox"/> <input type="checkbox"/> AIDS or ARC</li> <li><input type="checkbox"/> <input type="checkbox"/> Tumors, cancer</li> <li><input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism</li> </ul> | <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> <input type="checkbox"/> Eye disease</li> <li><input type="checkbox"/> <input type="checkbox"/> Skin diseases</li> <li><input type="checkbox"/> <input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> <input type="checkbox"/> VD (syphilis or gonorrhea)</li> <li><input type="checkbox"/> <input type="checkbox"/> Herpes</li> <li><input type="checkbox"/> <input type="checkbox"/> Kidney, bladder disease</li> <li><input type="checkbox"/> <input type="checkbox"/> Thyroid, adrenal disease</li> <li><input type="checkbox"/> <input type="checkbox"/> Taken Fen-Phen or appetite suppressants</li> </ul> |
|---|---|---|

*Do you have or have you had:*

- |  |   |
|--|---|
| <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Psychiatric care</li> <li><input type="checkbox"/> <input type="checkbox"/> Radiation treatments</li> <li><input type="checkbox"/> <input type="checkbox"/> Chemotherapy</li> <li><input type="checkbox"/> <input type="checkbox"/> Prosthetic heart valve</li> <li><input type="checkbox"/> <input type="checkbox"/> Artificial joint</li> <li><input type="checkbox"/> <input type="checkbox"/> Hospitalization</li> </ul> | <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Surgeries</li> <li><input type="checkbox"/> <input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> <input type="checkbox"/> Contact lenses</li> </ul> |
|--|---|

**(Continued)**

*Do you take:*

- |   |
|---|
| <p><b>Yes No</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Drug, medicines (including aspirin and birth control pills) List: _____</li> <li><input type="checkbox"/> <input type="checkbox"/> Bisphosphonates (eg. Fosamax, Boniva, Actonel, Azedia, Reclast, etc.)</li> <li><input type="checkbox"/> <input type="checkbox"/> Recreational drugs</li> <li><input type="checkbox"/> <input type="checkbox"/> Tobacco in any form</li> <li><input type="checkbox"/> <input type="checkbox"/> Alcohol</li> </ul> |
|---|

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. By providing my contact information, I hereby agree to allow Abari Orthodontics to contact me regarding patient healthcare and financial matters.*

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.

Dr. Signature: \_\_\_\_\_

### **Health History Review:**

**6 mos** Current Meds  
Changes in Health: \_\_\_\_\_

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Dodor's Signature: \_\_\_\_\_

**6 mos** Current Meds  
Changes in Health: \_\_\_\_\_

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Dodor's Signature: \_\_\_\_\_

**6 mos** Current Meds  
Changes in Health: \_\_\_\_\_

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Dodor's Signature: \_\_\_\_\_