

Please complete this health questionnaire as fully and completely as possible. Your confidentiality will be respected.

Name:

CHIEF CONCERN(S):

- Crowded teeth
- Over bite
- "Buck teeth"
- Receded jaw
- Prominent jaw
- Gummy smile
- Spacing between teeth
- Gum disease/recession
- Missing teeth
- Jaw dysfunction
- Mouth too small
- Clicking jaw joint
- Irregular teeth
- Protrusion of teeth
- Ears Ring/Stuffy
- Headache/Face pain
- Neck pain
- Jaw pain
- Irregular facial appearance
- Other: _____

CHECK ALL THAT APPLY:

- Frequent sore throat/tonsillitis
- Speech problems
- Pain in the RIGHT jaw joint
- Pain in the LEFT jaw joint
- Clicking/popping in RIGHT jaw joint
- Clicking/popping in LEFT jaw joint
- Current thumb/finger sucking habit
- Previous thumb/finger sucking habit
- Lip biting/sucking habit
- Grind teeth
- Clench jaws
- Tongue thrust when swallowing

CONDITIONS THAT YOU HAVE OR HAD:

- AIDS
- Allergies
- Asthma
- Autoimmune disorders
- Blood disease
- High blood pressure
- Low blood pressure
- Bone disorders
- Cancer
- Diabetes
- Dizziness
- Eating disorders
- Endocrine problems
- Emotional problems
- Female problems
- HIV positive status
- Hepatitis
- Heart disease
- Heart murmur
- Hearing disorder
- Kidney disease
- Rheumatic fever
- Ringing of the ears
- Sleep disturbance
- History of trauma
- Teeth Face Jaws Head
- None of the Above

KNOWN OR SUSPECTED ALLERGIES:

- Antibiotics: _____
- Pain pills: _____
- Foods: _____
- Environmental allergies: _____
- None

CURRENT MEDICATIONS:

- Heart pills: _____
- Antibiotics: _____
- Diet pills: _____
- Pain pills: _____
- Vitamins: _____
- Birth control pills: _____
- Muscle relaxants: _____
- Insulin: _____
- Other: _____
- _____
- _____
- _____
- None

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?

- Yes, please describe: _____
- _____
- _____
- _____

HAVE YOU HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?

- Yes: _____
- No

FREQUENCY OF DENTAL CHECKUPS?

- Once per year
- Twice per year
- More than twice a year
- Emergencies only
- Never

INTEREST IN ORTHODONTIC TREATMENT?

- Want treatment
- Only if necessary
- Unwilling
- But will cooperate if treatment is needed
- Uncooperative

ORTHODONTIC EXAM PROMPTED BY:

- Patient Spouse Dentist
- Friend Other

MARITAL STATUS:

- Married Divorced
- Separated Single
- Widowed Other

Responsible Party Signature

Printed Name

Date

Please visit our website at www.hodgesorthodontics.com to view your appointment and account history!

CONFIDENTIAL

ADULT

Date

Name _____

Gender: M / F

Likes to be referred to as: _____

Birth date ____/____/____ AGE: _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

Home Phone _____ Work _____ CELL _____

Email Address _____ (will be used for appt reminders)

Employer _____ Occupation _____ Social Security # _____ - _____ - _____

Current Dentist _____ How did you hear of us? _____

Spouse's Name (if applicable) _____
Last First Middle

Home Phone _____ Work _____ CELL _____

Birth date ____ - ____ - ____ Email Address _____ Social Security # _____ - _____ - _____

Employer _____ Occupation _____

Patient's Children

_____/_____/_____
Name Birth date Relationship

_____/_____/_____
Name Birth date Relationship

_____/_____/_____
Name Birth date Relationship

_____/_____/_____
Name Birth date Relationship

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Name Birth date Relationship