

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

**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

**HAS PATIENT 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

**CONDITIONS THE PATIENT HAS OR HAS 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: \_\_\_\_\_
- \_\_\_\_\_

Responsible Party Signature

Printed Name

Date

Please visit our website at [www.hodgesorthodontics.com](http://www.hodgesorthodontics.com) to view your appointment and account history!

Patient \_\_\_\_\_

Gender: M / F

Likes to be called: \_\_\_\_\_

STREET \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Patient lives with:  Both Parents  Mother  Father  Grandparent  Other: \_\_\_\_\_

PARENTS MARITAL STATUS  Married  Divorced\*\*\*  Widowed  Separated\*\*\*  Single

\*\*\*\*\* I \_\_\_\_\_ DO authorize \_\_\_\_\_ to receive financial information in regards to child's account. (This pertains to divorced parents i.e. step mom or dad.)

Current Dentist : \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

#1 Responsible Party 1 (guardian that will bring patient to appt): \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address \_\_\_\_\_ (will be used for appt reminders)

HOME Phone \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

MAILING ADDRESS IF DIFFERENT FROM PATIENT \_\_\_\_\_

Employer \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

#2 Responsible Party 2: (if applicable) \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ DOB \_\_\_\_\_

Email Address \_\_\_\_\_ (will be used for appt reminders)

MAILING ADDRESS IF DIFFERENT FROM PATIENT \_\_\_\_\_

HOME Phone \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PRIMARY INSURANCE THROUGH:  MOM  DAD  STEPPARENT  CHIPS

EMPLOYER AND SSN of PRIMARY INSURANCE HOLDER \_\_\_\_\_

Patient's Siblings

NAME

DOB

1.

2.

3.