EVANS ORTHODONTICS

New Patient Questionare

Today's Date: _____ Scanned: _____

PATIENTS UNDER 18			
(If over 18 please skip to next section)			
Patient's Name:		DOB:	Gender:
Nickname- Pt would like to be called?	School:		
Address:		City/State:	Zip:
Parent or Guardian: ****Please fill out next section****			
PATIENTS OVER 18 OR Parent/Guardian Information			
Name:		DOB:	Gender:
Address:		City, State	Zip:
Best Phone (C☐, H☐, W☐):	Other Phone(C☐, H☐, W☐):	Email Address:	
Employer:		Occupation:	
Spouse's Name:	Best Phone (C☐, H☐, W☐):	Relation to Patient:	
Employer:		Occupation:	
Who may we thank for referring you to our office?		***Other family members seen by us?***	
Other siblings to not seen currently by Evans Orthodontics (name and age)?			
Financial Responsible Party Information (if different from Parent or Guardian)			
Name:		Age: DOB:	Gender:
Address:		City, State	Zip:
Best Phone (C☐, H☐, W☐):	Other Phone(C☐, H☐, W☐):	Email:	
Employer:		Occupation:	
Dental Insurance Information or Provide Insurance Card			
Insured Name:		DOB:	
Employer:		Occupation:	
Insurance Company:		SS#:	
Insurance Company Phone #:		Member ID#:	
Insurance Company Address:		City: State:	Zip:
Emergency Information			
Name:		Relationship:	
Address:		City: State:	Zip:
Best Phone (C☐, H☐, W☐):		Alternate Phone (C☐, H☐, W☐):	

***See reverse side for Medical History Information

MEDICAL HISTORY

Physician _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medications? _____

Yes No Are you allergic to latex or metal? _____

Yes No Do you have a history of major illness? _____

Yes No Have had any major operations? _____

Yes No Have there been any injuries to the face, mouth, teeth or chin? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Have you ever smoked or chewed tobacco? _____

Yes No Have you seen a physician in the last 12 months? Why? _____

FEMALE PATIENTS ONLY

Yes No Are you pregnant?

Yes No Has menstruation started? Month/year menstruation began? _____

CIRCLE any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

DENTAL HISTORY

Dentist: _____ Date Of Last Visit: ____/____/_____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? Explain: _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? Explain _____

Yes No Have you ever lost or chipped any teeth?

Yes No Is any part of your mouth sensitive to temperature or pressure?

Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb or tongue habit?

Yes No Do you bite your fingernails or have tongue thrust?

Yes No Are you a mouth breather?

Yes No Have you had your tonsils or adenoids removed?

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

How did they feel about the result? _____

What is your attitude toward receiving orthodontic treatment? _____

Yes No Would you object to wearing orthodontic appliances (braces)?

Yes No Has anyone in your family received orthodontic treatment? If so, who? _____

Yes No Do your teeth or jaw ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? Explain: _____

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?

Yes No Do you have "tension" headaches?

Yes No Have you ever experienced chronic ringing in your ears?

Yes No Are you aware that some appointments will be during school/work hours?

Are you happy with the way your smile looks? _____ YES _____ NO

BENEFITS OF ORTHODONTICS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughtout our lifetime and there can be some movement of the teeth and some change after treatment.

I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Evans to perform a complete orthodontic evaluation.

Signature: _____ Date: _____