A B C D X

alexanderorthodontics
{making generations smile}

Date _____

Patient's name Mr. Dr. Mrs. Ms. _____
Last First Middle Nickname

Male ☐ Female ☐ Age _____ Birthdate _____ Social Security# _____

Chief reason for seeking treatment? _____

Patient's Dentist _____

Relatives Treated at Alexander Orthodontics _____

Whom may we thank for referring you to our office? _____

Employer _____ Occupation _____ No. years employed _____

Address _____
Street City State Zip

How long at this address? _____ If you've lived in current residence for less than 3 years please provide previous address.

Home phone _____ Work phone _____ Cell/other phone _____

Email address _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Married ☐ Separated ☐ Divorced ☐

Spouse's Social Security# _____ Birthdate _____

Address _____
Street City State Zip

Spouse's Employer _____ Occupation _____

No. years employed _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____ D.O.B _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes ☐ No ☐ *If yes:*

Insured's Name _____ Insured's Social Security # _____ D.O.B _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Phone _____

Complete address _____
Street City State Zip

I have received the privacy policies of Alexander Orthodontics, and I understand that, where appropriate, credit bureau reports may be obtained.

☐ *I decline credit.*

Signature _____

Updates (date & initial) _____

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Thank you for completeing this questionnaire. This information helps us provide the best orthodontic care.

MEDICAL HISTORY (Please circle either Y for yes or N for no)

Have there been any injuries to the face, mouth or chin? **Y N**
Have adenoids/tonsils been removed? **Y N**
Are you currently under the care of a physician? **Y N**
Are your immunizations current? **Y N**

Please list all drugs you are currently taking:

_____
_____
_____

Are you allergic to:
Latex/Metals **Y N**
Nickel **Y N**
Plastic **Y N**

Please list any other allergies:

_____

Please describe your physical health:
☐ Good ☐ Fair ☐ Poor

Have you experienced the following medical problems?

Abdominal Bleeding	Y N	Hearing Impairment	Y N
ADD/AHD	Y N	Heart Murmur	Y N
AIDS/HIV	Y N	Hemophilia	Y N
Any hospital stays/ Surgeries	Y N	Hepatitis	Y N
Artificial Bones/Joints/Valves	Y N	Kidney Problems	Y N
Asthma	Y N	Liver Problems	Y N
Cancer	Y N	Mitral Valve Prolapse	Y N
Congenital Heart Defect	Y N	Prosthetics	Y N
Convulsions	Y N	Rheumatic Fever	Y N
Diabetes	Y N	Scarlet Fever	Y N
Handicaps/Disabilities	Y N	Tuberculosis (TB)	Y N

Please describe any serious medical issues you have:

_____
_____

DENTAL HISTORY

Dentist Name_____
Date of Last Cleaning _____
How often do you get your teeth cleaned?_____

Do you require antibiotics before dental treatment? **Y N**
Do you have any missing permanent teeth? **Y N**
Do you brush your teeth daily? **Y N**
Do you play a musical instrument? **Y N**
Type: _____
Have you had any pain or tenderness in your jaw (TMJ/TMD)? **Y N**
Have you had dental surgery? **Y N**
Have you had prior orthodontic consultation or treatment? **Y N**

Do you have any of the following habits?

Clenching/Grinding Teeth	Y N
Lip Sucking/Biting	Y N
Mouth Breathing	Y N
Nail Biting	Y N
Speech Issues	Y N
Tongue Thrust	Y N
History of Smoking	Y N
Thumb/Finger Sucking	Y N

Please explain any other conditions or issues we should be aware of: _____

_____

Describe your orthodontic problem in your own words: _____

_____

I certify that the information is accurate and that I will inform Dr. Alexander's office of any changes to this information.

Signature _____ Date _____