alexanderorthodontics
{making generations smile}

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 _____
Past Periodontal Treatment _____
Frequency of Periodontal Visits _____

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? Type: _____ Y N
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 _____

A B C D X

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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 Here _____

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

Spouse's Name _____ Married ☐ Separated ☐ Divorced ☐

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.

Previous Address _____
Street City State Zip

Home phone _____ Work phone _____ Cell/other phone _____

Email address _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Social Security# _____ Birthdate _____

Spouse's Employer _____ Occupation _____

No. years employed _____ Work 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) _____