(Adult)

Southern Minnesota Orthodontics, P.A.

DRS. KANYUSIK, WIEMERS AND SWANSON

Patient #

Date: ___________________________

Please assist us by completing the following questions:

Patient's Name: Sex: Age: Birthdate:

Patient's Social Security #: Home #:

Address: City: Zip: Cell #:

Email address: Would you like to receive appointment reminders by email: ☐ Yes ☐ No

Employed By: Occupation: Work Phone:

Marital Status: ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

Spouse's Name: Occupation: Work Phone:

Spouse's Social Security #: Referred by:

Employed By:

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Other:

Address: Business Phone: Home Phone:

ORTHODONTIC INSURANCE

Primary **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

Secondary **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

I understand I am responsible for any balance not covered by insurance.

I authorize payment to be made directly to the orthodontist who has provided these services. **Signature** ______________________________ **Date** ________________

DENTAL HISTORY

Patient's Dentist: Date of Last Visit:

1. Have there been any injuries to the face, mouth or teeth? ☐YES ☐NO
2. Have you had or do you presently have any of the following habits? ☐NO ☐Thumb or finger sucking ☐Lip biting ☐Grinding of teeth at night ☐Mouth breathing
3. Have you been informed of any missing or extra permanent teeth? ☐YES ☐NO
4. Are you aware of sores, lumps or irritated areas in the mouth? ☐YES ☐NO
5. Has an orthodontist been consulted previously? ☐YES ☐NO
   Name: Date:
6. Have you ever been treated for: ☐Bite problem ☐TMJ ☐Periodontal disease ☐NO
   If so, by whom?
7. Do you have any speech problems? ☐YES ☐NO
8. Are you frightened or anxious about orthodontic treatment? ☐YES ☐NO
9. Are you concerned about the appearance of your teeth? ☐YES ☐NO
10. Is there anything you would like to change about your smile? ☐YES ☐NO
    If so, what:
11. Reason for consultation: ______________________________
12. Has there ever been any orthodontic treatment for any other member of your family? ☐YES ☐NO Spouse (Dr. ________________)
    Sons (Dr. ________________) Daughters (Dr. ________________) Brothers (Dr. ____________________) Sisters (Dr.________________)
13. Are you satisfied with their results? ☐YES ☐NO

(over)

MEDICAL HISTORY

1. What is the name of your family physician? Date of last physical:
2. Is your general health good at this time? ☐ YES ☐ NO
3. Are you under the care of a physician at this time? ☐ YES ☐ NO
   Explain:
4. Are you taking any medications? ☐ YES ☐ NO
   Name:
5. Are you allergic to any medication? ☐ YES ☐ NO
   Name:
6. Have you had your tonsils and adenoids removed? ☐ YES ☐ NO
   Age:
7. Have you ever had a serious illness or been hospitalized? ☐ YES ☐ NO
   Explain:
8. Do you have any special problems not listed? ☐ YES ☐ NO
   Explain:
9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? ☐ YES ☐ NO
   If yes, antibiotic name and method:
10. WOMEN: ☐ YES ☐ NO
    Are you pregnant or considering pregnancy during the next 2 years?

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

YES	NO	
☐	☐	Endocarditis
☐	☐	Heart Condition
☐	☐	Heart Pacemaker
☐	☐	Heart Angina
☐	☐	Heart Attack (coronary)
☐	☐	Mitral Valve Prolapse
☐	☐	Congenital Heart Disease
☐	☐	Artificial Heart Valve
☐	☐	Heart Surgery/Date ____________
☐	☐	Heart Murmur
☐	☐	Rheumatic Fever
☐	☐	Prosthetic (artificial) Joint
☐	☐	X-Ray/Radiation (cancer) Therapy
☐	☐	Respiratory Lung Disease
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Hepatitis

YES	NO	
☐	☐	Tuberculosis
☐	☐	AIDS or H.I.V. Positive
☐	☐	Venereal Disease
☐	☐	Herpes (oral-cold sores)
☐	☐	Blood Disorder
☐	☐	Inflammatory Rheumatism
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Ulcers
☐	☐	Stroke
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Fainting Spells
☐	☐	Kidney Trouble
☐	☐	Liver Disease

YES	NO	
☐	☐	Psychiatric Treatment
☐	☐	Drug Addiction
☐	☐	Headaches
☐	☐	Earaches
☐	☐	Jaw Clicking
☐	☐	Allergies
☐	☐	Jaw Pain
☐	☐	Tonsillitis
☐	☐	Emotional Problems
☐	☐	Snoring
☐	☐	Sleep Apnea
☐	☐	Cancer
☐	☐	Osteoporosis
☐	☐	Other ______________

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising from inadequate information or information not disclosed. I UNDERSTAND THAT THE VISUAL EXAMINATION IS FREE OF CHARGE, HOWEVER THERE WILL BE A CHARGE FOR ANY DIAGNOSTIC RECORDS DEEMED NECESSARY.

Signature of patient

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Signature of Orthodontist

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Today's Date ______________________________

Update ______________________________ Initial _______

Update ______________________________ Initial _______

Update ______________________________ Initial _______

Update ______________________________ Initial _______

NOTES:

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