

(Adult)

--	--	--	--

Southern Minnesota Orthodontics

Drs. Kanyusik, Wiemers & Swanson

Patient # _____

Date: _____

Please assist us by completing the following questions:

Patient's Name: _____ Sex: _____ Age: _____ Birthdate: _____

Patient's Social Security #: _____ Referred by: _____

Nickname: _____ Home E-mail: _____

Address: _____ City: _____ Zip: _____ Home #: _____
Cell #: _____

Employed By: _____ Occupation: _____ Work Phone: _____

Marital Status: Single Married Remarried Separated Divorced Widowed E-Mail: _____

Spouse's Name: _____ Occupation: _____ Work Phone: _____

Spouse's Social Security #: _____ E-Mail: _____

Employed By: _____

Person Responsible for Account: Self Spouse Other: _____

Address: _____ Business Phone: _____ Home Phone: _____

ORTHODONTIC INSURANCE

Primary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ SS#: _____ Birthdate: _____

Secondary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ SS#: _____ Birthdate: _____

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
If so, by whom? NO

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?
Explain: _____ | □ YES □ NO |
| 4. Are you taking any medications?
Name: _____ | □ YES □ NO |
| 5. Are you allergic to any medication?
Name: _____ | □ YES □ NO |
| 6. Have you had your tonsils and adenoids removed?
Age: _____ | □ YES □ NO |
| 7. Have you ever had a serious illness or been hospitalized?
Explain: _____ | □ YES □ NO |
| 8. Do you have any special problems not listed?
Explain: _____ | □ YES □ NO |
| 9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments?
If yes, antibiotic name and method: _____ | □ YES □ NO |
| 10. WOMEN:
Are you pregnant or considering pregnancy during the next 2 years? | □ YES □ NO |

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

- | YES | NO | YES | NO | YES | NO |
|--------------------------|---|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> AIDS or H.I.V. Positive | <input type="checkbox"/> | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Angina | <input type="checkbox"/> | <input type="checkbox"/> Herpes (oral-cold sores) | <input type="checkbox"/> | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Attack (coronary) | <input type="checkbox"/> | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> Jaw Clicking |
| <input type="checkbox"/> | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> Inflammatory Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Surgery/Date _____ | <input type="checkbox"/> | <input type="checkbox"/> Ulcers | <input type="checkbox"/> | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> | <input type="checkbox"/> Prosthetic (artificial) Joint | <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> X-Ray/Radiation (cancer) Therapy | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> Respiratory Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Fainting Spells | | |
| <input type="checkbox"/> | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Kidney Trouble | | |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Liver Disease | | |

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.

Signature of patient _____ Signature of Orthodontist _____	Today's Date _____ Update _____ Initial _____ Update _____ Initial _____ Update _____ Initial _____ Update _____ Initial _____
---	--

NOTES:
