(Adult)

# *Southern Minnesota Orthodontics, P.A.*

Drs. Kanyusik, Wiemers, Swanson and Vaubel

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

_____

Signature of Orthodontist

_____

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

## NOTES:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.