

# WELCOME TO AMHERST ORTHODONTICS

ADULT

We would like to welcome you to our office. Our goal is to make your visit pleasant and educational.

The contents of this questionnaire are strictly confidential and will become part of the dental record. Thank you for filling out the information below.

## PERSONAL INFORMATION

Title, First, Last Name:			<input type="checkbox"/> M <input type="checkbox"/> F												
Preferred Name:			Birth Date:												
Mailing Address:	City	State	Zip:												
Home Phone:	Work Phone:		Cell Phone:												
Social Security:	Employer:		Occupation:												
Who noticed an orthodontic problem?    You/Family <input type="checkbox"/> Dentist <input type="checkbox"/> Other:															
What are your orthodontic concerns?															
<p>How did you hear about us and whom may we thank for the referral? (check box below)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> My hygienist</td> <td>Name: _____</td> <td><input type="checkbox"/> A school visit by the doctors: _____</td> </tr> <tr> <td><input type="checkbox"/> My dentist</td> <td>Name: _____</td> <td><input type="checkbox"/> Internet Search. keywords used: _____</td> </tr> <tr> <td><input type="checkbox"/> My friend/coworker/neighbor</td> <td>Name: _____</td> <td><input type="checkbox"/> Newspaper. Which One? _____</td> </tr> <tr> <td><input type="checkbox"/> Your staff member referred me</td> <td>Name: _____</td> <td><input type="checkbox"/> Other. Please explain: _____</td> </tr> </table>				<input type="checkbox"/> My hygienist	Name: _____	<input type="checkbox"/> A school visit by the doctors: _____	<input type="checkbox"/> My dentist	Name: _____	<input type="checkbox"/> Internet Search. keywords used: _____	<input type="checkbox"/> My friend/coworker/neighbor	Name: _____	<input type="checkbox"/> Newspaper. Which One? _____	<input type="checkbox"/> Your staff member referred me	Name: _____	<input type="checkbox"/> Other. Please explain: _____
<input type="checkbox"/> My hygienist	Name: _____	<input type="checkbox"/> A school visit by the doctors: _____													
<input type="checkbox"/> My dentist	Name: _____	<input type="checkbox"/> Internet Search. keywords used: _____													
<input type="checkbox"/> My friend/coworker/neighbor	Name: _____	<input type="checkbox"/> Newspaper. Which One? _____													
<input type="checkbox"/> Your staff member referred me	Name: _____	<input type="checkbox"/> Other. Please explain: _____													

## FAMILY INFORMATION

SPOUSE'S NAME (if applicable):	Preferred Name
Sons (with ages):	
Daughters (with ages):	
Have any family members or relatives received orthodontic treatment?	Please Name:

## DENTAL HISTORY

General Dentist:	Date of last cleaning:	Date of last X-rays:	
Is there any pending dental work?			
Have you ever been evaluated for, or previously had, orthodontic treatment?			
Have there been any injuries to your face, mouth, teeth or chin? If yes, describe injury and indicate when trauma occurred.			
Have you ever been seen by or referred to a periodontist?	Name of periodontist:		
Have you ever had periodontal surgery (gum graft, bone graft, deep cleaning, implants etc.)?			
Check any of the following dental issues, which apply			
Clenching teeth	Jaw joint soreness	Muscle soreness around head & neck	Mouthbreathing
Grinding teeth	Jaw joint clicking	Wearing night guard	Nail biting
Frequent Headaches	Jaw joint popping	History of jaw locking	Snoring
Speech problems or tongue thrusting? Please elaborate			
Have you ever worn a nighttime flexible or rigid mouthguard or splint?    Yes <input type="checkbox"/> No <input type="checkbox"/>			Why?

## MEDICAL HISTORY

<b>Physician:</b>				<b>Date of last exam:</b>			
Are you in good health?      Yes <input type="checkbox"/> No <input type="checkbox"/>			Are you currently under a physician's care?      Yes <input type="checkbox"/> No <input type="checkbox"/>				
Tobacco Use (smoking)?      Yes <input type="checkbox"/> No <input type="checkbox"/>			Do you need to premedicate for dental visits?      Yes <input type="checkbox"/> No <input type="checkbox"/>				
Women only: Are you pregnant or anticipate becoming pregnant?      Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>Check any of the following medical issues, which apply:</b>							
Allergies	Arthritis	Blood disorder / Anemia	Cancer	Diabetes	Hepatitis	Sinus trouble	Rheumatic fever
Anxiety	Asthma	Bone disorders / Osteoporosis	Cold Sores	Heart Murmur	Pregnancy	Tuberculosis (TB)	Kidney Disease
HIV + / AIDS	Psychological / Emotional Issues		Migraines / Frequent headaches				
<b>Please provide additional information on any above circled medical issues or any other conditions?</b>							
<b>Please list any drugs/medications you are currently taking:</b>							
Are you currently taking or have previously taken Fosamax or bone restoring medications?      Yes <input type="checkbox"/> No <input type="checkbox"/>				If so, for how long?			
<b>Are you allergic to any medicines, local anesthesia (Novocaine or Lidocaine),rylic, latex, or metals? If yes, please specify:</b>							

*I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my medical/dental status or personal information.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*