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:			**☐ M ☐ F**
Preferred Name:			**Birth Date:**
Mailing Address:	**City**	**State**	**Zip:**
Home Phone:	**Work Phone:**		**Cell Phone:**
Social Security:	**Employer:**		**Occupation:**
Email:	**Who noticed an orthodontic problem? You/Family ☐ Dentist ☐ Other:**		
What are your orthodontic concerns?			

How did you hear about us and whom may we thank for the referral? (*check box below*)

☐ My hygienist **Name: _____**
☐ My dentist **Name: _____**
☐ My friend/coworker/neighbor **Name: _____**
☐ Your staff member referred me **Name: _____**

☐ A school visit by the doctors: _____
☐ Internet Search. keywords used: _____
☐ Newspaper. Which One? _____
☐ 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.)?		

Circle any of the following dental issues, which apply

Clenching teeth	Jaw joint soreness	Muscle soreness around head & neck	Mouth breathing
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 mouth-guard or splint? Yes ☐ No ☐	**Why?**

MEDICAL HISTORY

Physician:	**Date of last exam:**
Are you in good health? Yes ☐ No ☐	**Are you currently under a physician's care?** Yes ☐ No ☐
Tobacco Use (smoking)? Yes ☐ No ☐	**Do you need to pre-medicate for dental visits?** Yes ☐ No ☐
Women only: Are you pregnant or anticipate becoming pregnant? Yes ☐ No ☐	

Circle any of the following medical issues, which apply:

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				

Please provide additional information on any above circled medical issues or any other conditions?

Please list any drugs/medications you are currently taking:

Are you currently taking or have previously taken Fosamax or bone restoring medications? Yes ☐ No ☐	**If so, for how long?**

Are you allergic to any medicines, local anesthesia (Novocaine or Lidocaine), arylic, latex, or metals? If yes, please specify:

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