HOCH ORTHODONTICS
creating beautiful smiles

Member American Association of Orthodontists

PATIENT QUESTIONNAIRE

NAME_____

DATE OF BIRTH_____ Age _____ Years _____ Months SEX [ ] M [ ] F

ADDRESS: Street _____

City _____ State _____ Zip _____

TELEPHONE: Residence ( ) _____ Business ( ) _____

OCCUPATION/Grade in School: _____

PERSON RESPONSIBLE FOR FINANCIAL MATTERS:

Name: _____

Address: Street _____

City _____ State _____ Zip _____

Telephone: Residence ( ) _____ Business ( ) _____

DOES PATIENT HAVE INSURANCE FOR ORTHODONTIC TREATMENT? ( ) Yes ( ) No

1. FAMILY STATUS:

Father's Name _____ Work Phone _____

Mother's Name _____ Work Phone _____

2. MEDICAL HISTORY:

Family Physician _____ Phone ( ) _____

Address _____

Has Patient Ever Had:

( ) AIDS	( ) Cerebral Palsy	( ) Hepatitis
( ) Anemia	( ) Cold Sores	( ) Injury to Face
( ) Arthritis	( ) Diabetes	( ) Kidney Disease
( ) Asthma	( ) Epilepsy/Seizures	( ) Lung Disease
( ) Allergy	( ) Hearing Problem	( ) Oral Ulcers
( ) Bleeding	( ) Heart Condition	( ) Previous Surgery
		( ) Rheumatic Fever

Specify: _____

_____

Other Illness: _____

Is the patient receiving any medication? ( ) Yes ( ) No
Is the patient allergic to any medication? ( ) Yes ( ) No
Is the patient allergic to anything else? ( ) Yes ( ) No

Specify: _____

Does the patient need to be premedicated (antibiotics) for routine dental procedures? ( ) Yes ( ) No

If yes, specify and give reason for use _____

_____

Have the patient's tonsils and/or adenoids been removed? ( ) Yes ( ) No

If yes, at what age? _____ Years

Other operations ( ) Yes ( ) No

If yes, describe _____

_____

3. DENTAL HISTORY:

Family Dentist _____ Phone ( ) _____

Address _____

Date of last dental examination _____

Injuries or trauma to the teeth or gums? ( ) Yes ( ) No

If yes, please specify _____

How often does the patient brush his/her teeth?

( ) Several times a day ( ) Occasionally
( ) Once or twice a day ( ) Never

Has the patient ever had:
Unfavorable dental experiences? ( ) Yes ( ) No

Specify _____

Speech Therapy? ( ) Yes ( ) No

Does or did the patient

Grind his/her teeth at night? ( ) Yes ( ) No
Bite his/her fingernails? ( ) Yes ( ) No
Suck thumb, finger, pacifier, etc.? ( ) Yes ( ) No

If yes, at what age did he/she discontinue? _____ Years
Does the patient's home water supply have fluoride? ( ) Yes ( ) No

4. PATIENT'S TREATMENT ATTITUDE:

Is the patient aware of an orthodontic problem? ( ) Yes ( ) No

Orthodontic consultation was prompted by _____

The patient's interest in orthodontic treatment is:

( ) Wants treatment
( ) Willing if treatment is necessary
( ) Unwilling

5. OTHER:

Describe the main reason why you are, or your child is, seeking orthodontic treatment

_____

Signature of individual completing this form: _____

Relationship to patient: _____Today's Date: _____