(For Patients Over Age 18)

Today's Date ____________________

Patient Name ____________________ Prefers to be called ____________________

Address ____

City, State, Zip ____

Home Phone ____________________ Work Phone ____________________

Occupation ____________________ Employed By ____________________

Spouse's Name ____________________ Work Phone ____________________

Occupation ____________________ Employed By ____________________

Who may we contact in case of emergency? ____________________ Phone ____________

Family Dentist ____________________ Family Physician ____________________

In your opinion, what is your orthodontic problem? ____________________

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Who may we thank for recommending you to our office? ____________________

Person responsible for account ____

SSN ____________________ Birthdate ____________ Age ______ Sex M F

Address ____

City, State, Zip ____

Do you have orthodontic insurance coverage? ❍ No ❍ Yes, company ____________________

Group Number ____________________ Phone/Contact ____________________

TranOrthodontics

HEALTH QUESTIONNAIRE

Today's Date_______________

Patient Name______________________________________ Birthdate________________

Family Dentist______________________________ Date of last visit_________________

Have you ever had the following dental treatment?

☐ Orthodontics, date ___________, by Dr.__________________________________
☐ Periodontal treatment (gum treatment)
☐ Mouthguard or splint therapy for jaw joint problems
☐ Jaw surgery to change your bite or to correct jaw joint

Do you have or have you had any of the following oral conditions?

☐ Sensitive teeth
☐ Clenching or grinding
☐ Bad breath
☐ Pain in the jaw, face
☐ Dry mouth
☐ Poorly functioning teeth
☐ Bleeding gums
☐ Pain around ear
☐ Mouth breathing
☐ Oral habits (thumb sucking, etc)
☐ Pain when opening mouth
☐ Discolored teeth
☐ Food wedging between teeth
☐ Swelling or lumps in the mouth
☐ Tobacco use
☐ Jaw joint sounds or pain
☐ Inability to floss between teeth
☐ Jaw gets stuck open or closed

Do you have or have you had any of the following medical conditions?

☐ Rheumatic fever
☐ Diabetes
☐ Inflammatory rheumatism
☐ Asthma
☐ Liver disease
☐ Severe headaches
☐ Eye problems
☐ Nose bleeds
☐ Easy bruising
☐ Congenital heart lesions / murmur
☐ Anemia
☐ Kidney problems
☐ Yellow jaundice
☐ High blood pressure
☐ Dizziness or fainting
☐ Ear problems
☐ Speech problems
☐ Venereal disease
☐ Heart condition
☐ Arthritis, swollen joints
☐ Tuberculosis
☐ Hepatitis type ______
☐ Low blood pressure
☐ Convulsions or seizure
☐ Sinus problems
☐ Swallowing problems
☐ HIV positive

Are you currently under a physician's care? If yes, describe__________________________________ ☐ yes ☐ no
Has patient ever been hospitalized or had any serious illness? If yes, describe__________________ ☐ yes ☐ no
Does the patient have any drug allergies? If yes, list medications______________________________ ☐ yes ☐ no
Is the patient allergic to latex? ____ ☐ yes ☐ no
Is the patient taking any medication? If yes, list medications__________________________________ ☐ yes ☐ no
Female patients – could patient possibly be pregnant at the present time?______________________ ☐ yes ☐ no

Patient (or parent) signature____ **Date**_______________

Dr. Tran's notes:

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