ORTHODONTIC DENTAL & MEDICAL QUESTIONNAIRE
BRACES IN MARKHAM

Patient's Full Name:_____Age:_____Sex:_____

Date of Birth: _____Home Phone Number:_____

Home Mailing Address:_____

Parent/Guardian Name:_____Work Number:_____Cell Number:_____

Home Mailing Address:_____

Parent/Guardian Name:_____Work Number:_____Cell Number:_____

Home Mailing Address:_____

Patient lives with:_____Patient'sSchool:_____Grade:_____

Email address:_____

Number of Siblings of Patient: Ages ( ) ( ) ( ) ( )

Were you referred by your dentist? Friend?_____ Other?_____

What is your orthodontic concern?_____

Will you be needing us to complete insurance forms? (Circle One) Yes / No

Dental History

Patient's dentist:_____Age first seen by dentist:_____

What age did baby teeth first erupt?_____How often are teeth brushed?_____

Has the patient had any major dental procedures? Extractions?_____Root Canal?_____Gum Surgery?_____

Have there been any injuries to the head, face or teeth?_____

Does the patient clench or grind teeth?_____Any finger or thumb sucking?_____

Has the patient ever been seen by an orthodontist?_____

Is there any difficulty chewing or swallowing?_____Is there any pain opening or closing?_____

Have other family members had orthodontic treatment?_____

Braces? Appliances? Extractions? Surgery?

Medical History

Patient's doctor:_____(phone#)_____Present Health: Good Fair Poor

Are there any medical conditions?:_____

Date of last visit to doctor:_____Reason:_____

Have tonsils or adenoids been removed?_____Any difficulty breathing?_____Asthma?_____

Are there any speech problems?_____Classes/Treatment?_____

Does the patient bleed or bruise easily?_____What medication is the patient taking?_____

Are there environmental/food/drug/latex/metal allergies?_____

Has the patient been hospitalized for any reason?_____

Is there a history of Rheumatic Fever, Convulsions, Diabetes, Repeated Headaches/Sore Throats/Colds?_____

DATE: _____SIGNATURE_____

Billing name for account:_____Phone Number:_____

Address:_____