ADULT ORTHODONTIC DENTAL AND MEDICAL QUESTIONAIRE
BRACES IN MARKHAM

Patient's Full Name:_____Age:_____Sex:_____

Date Of Birth:_____Home Phone Number:_____

Home Mailing address:_____

Occupation:_____Cell #_____Work #_____

Were you referred by your dentist?_____Friend?_____Other?_____

Email address: _____

Dental History

Patient's Dentist:_____Other Dental Care Providers:_____

What is your orthodontic concern?_____

Have you ever been seen by an orthodontist?_____

Does anyone else in the family have a similar condition?_____

Have they had treatment?_____Braces?_____Appliances?_____Extractions?_____Surgery?_____

Have you had any major dental procedures? Root canal?____ Extractions?____Gum Surgery?____Other?____

Have you had any injuries to your head, face or teeth?_____

Do you clench or grind your teeth?_____

Have you ever sucked a thumb or finger?_____To age?_____Other habits?_____

Do you have any difficulty eating, chewing, or swallowing?_____

Do you have any pain or clicking on opening or closing your jaws?_____

Do you have any speech problems?_____

How often do you brush your teeth?_____

How would you classify your intake of sweets? High Medium Low

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

Medical History

Patient's Doctor:_____(Phone #) _____Present Health: Good Fair Poor

Date of last visit to doctor:_____Reason:_____

Are you pregnant? Please advise us if you do become pregnant.

Do you have any difficulties breathing, awake or asleep, through your nose?_____Asthma?_____

Do you snore at night or have you ever been recommended by your physician to have a sleep test?_____

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

Any history of heart problems or joint replacement_____Do you need premedication?_____

Are you allergic to anything?_____Do you bleed or bruise easily?_____

Have you been hospitalized for any reason?_____

Do you have any chronic conditions?_____

List the medications you are taking:_____

Do you have a communicable (infectious) disease?_____

Signature _____ Today's Date_____