LakePointe Orthodontics
Patient Friendly...Committed to Excellence

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Orthodontic Specialists

GET ACQUAINTED QUESTIONNAIRE

ADULT

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's full name _____Date of Birth _____ Age _____ Phone _____
Address_____City_____State_____Zip_____
Email Address_____Cell Phone_____
Family Dentist_____City_____Phone_____Last Visit:_____
Family Physician_____City_____Phone_____
Name patient likes to be called_____
Sports, Hobbies, etc._____
Single_____Married_____Separated_____Divorced_____Widowed_____
Children (names/ages)_____
Major reason for seeking orthodontic treatment_____
How did you hear about our office?_____

DENTAL HISTORY

	No	Unsure	Yes	
Have there been any injuries to the face, mouth or teeth?	☐	☐	☐	notes:_____
Are you aware of any missing or extra permanent teeth?	☐	☐	☐	notes:_____
Do you have any speech problems or concerns?	☐	☐	☐	notes:_____
Are you especially apprehensive toward dental visits?	☐	☐	☐	notes:_____
Do you:				
• clench or grind your teeth?	☐	☐	☐	notes:_____
• brush your teeth conscientiously?	☐	☐	☐	notes:_____
Do you have:				
• a history of periodontal (gum) problems?	☐	☐	☐	notes:_____
• a problem with frequent cold/canker sores?	☐	☐	☐	notes:_____
• any difficulty opening your mouth?	☐	☐	☐	notes:_____
• any clicking or discomfort in jaw joints near ears?	☐	☐	☐	notes:_____
• headaches or neckaches regularly?	☐	☐	☐	notes:_____
• pain in the jaw joints while eating?	☐	☐	☐	notes:_____
• any congenital abnormalities? (cleft palate, etc.)	☐	☐	☐	notes:_____

ATTITUDE TOWARD TREATMENT

Are you aware of spaced, crooked or protruding teeth? ☐ No ☐ Yes Concerned? ☐ No ☐ Yes
Do you feel that it is becoming ☐ Better ☐ Worse ☐ Staying the Same
What would you most like to have orthodontic treatment accomplish? _____
Are you aware that some appointments will infringe upon school/work time? ☐ No ☐ Yes
Have you had any previous orthodontic examinations? ☐ No ☐ Yes Doctor:_____Date:_____
Have you had any previous orthodontic treatment?_____Describe:_____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Please check no or yes to the following and indicate the year:

	No	Yes	Years		No	Yes	Years
Attention Deficit Disorder	____	____	____	Hay Fever	____	____	____
Allergies	____	____	____	Healing Disorder	____	____	____
Anemia or Bleeding Problems	____	____	____	Headaches	____	____	____
Arthritis	____	____	____	Hearing Disorder	____	____	____
Asthma	____	____	____	Heart Disorders (murmur, etc.)	____	____	____
Behavioral Problems	____	____	____	Hepatitis or Liver Disorders	____	____	____
Bone or Joint Disorder	____	____	____	HIV Positive	____	____	____
Breathing or Nasal Disorder	____	____	____	Kidney or Bladder Condition	____	____	____
Diabetes	____	____	____	Mononucleosis	____	____	____
Earaches	____	____	____	Nervous Disorders	____	____	____
Epilepsy or Convulsions	____	____	____	Psychiatric Treatment	____	____	____
Fainting or Dizziness	____	____	____	Psychological Disorder	____	____	____
Gagging or Nausea Problems	____	____	____	Rheumatic Fever	____	____	____
Growth or Endocrine Condition	____	____	____	Sexually Transmitted Infection	____	____	____

General health: Good_____Fair_____Poor_____Birth Defects_____

Presently under medical care for_____

Drugs or medication being taken now (drug and dose)_____

Allergic to any medication_____

Do you require antibiotic premedication prior to dental appointments?..... ☐ No.... ☐ Yes

Are you a mouth breather?..... ☐ No..... ☐ Yes..... ☐ While asleep.....☐ While awake

Have tonsils and adenoids been removed?.... ☐ No..... ☐ Yes..... At what age?_____

Do you snore at night?..... ☐ No..... ☐ Yes

RESPONSIBLE PARTY INFORMATION

Name _____

Residence _____

Mailing Address _____ Zip

How long at this address _____ Home Phone _____ Work Phone_____ Zip

Social Security #_____ Birthdate _____ Relationship to Patient_____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Spouse's Address _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Emergency contact person _____

Name Home Phone Work Phone

ORTHODONTIC INSURANCE INFORMATION

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____

Do you have dual coverage? ☐ No ☐ Yes If Yes:

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian _____ Date _____

I give permission for x-rays and photographs to be used for research/educational purposes _____

Initials