

NEW PATIENT QUESTIONNAIRE



South Salem Orthodontics

STRAIGHT FORWARD ORTHODONTICS.

SALEM
1790 Liberty Street SE
Salem, OR 97302
(503) 588-2404 FAX (503) 588-8843

DALLAS
410 E. Ellendale, Suite 4
Dallas, OR 97338
(503) 623-6532

Date

Patient's Name Last First Middle

Address Street City State Zip

Home Phone Alternate # Birthdate

Mother's Name (if minor) Father's Name (if minor)

RESPONSIBLE PARTY INFORMATION

Primary Responsible Party Last First Middle Initial SS#

Residence Street City State Zip

Mailing Address Street City State Zip

How long at this address? Home Phone Work Phone

Previous Address (if less than 3 yrs.) Street City State Zip

Birthdate Relationship to Patient Spouse's Name

Employer Occupation # Years Employed

Secondary Responsible Party Last First Middle Initial SS#

Residence Street City State Zip

Mailing Address Street City State Zip

How long at this address? Home Phone Work Phone

Previous Address (if less than 3 yrs.) Street City State Zip

Birthdate Relationship to Patient Spouse's Name

Employer Occupation # Years Employed

DENTAL INSURANCE INFORMATION

Insured's Name Insured's ID#

Insurance Company Group # Phone #

Insurance Co. Address

Do you have dual coverage? Yes No If yes:

Insured's name Insured's ID#

Insurance Company Group # Phone #

Insurance Co. Address

Insured's Employer

EMERGENCY INFORMATION

Name of relative not living with you Phone #

Complete Address Street City State Zip

Please Complete Other Side

MEDICAL HISTORY

Patient's Physician _____

Is the patient in good health? Yes No

Has the patient seen a physician in the last 2 years? Yes No

What was the reason for the visit? _____

List any drugs or medication now being taken:

List any allergies or drug sensitivity:

Does the patient wear contact lenses? Yes No

Check any of the following for which the patient has been diagnosed and/or treated:

- | | | |
|---------------------|------------------------------|-----------------------------|
| Anemia | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Arthritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Bone Disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainting/Dizziness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Glaucoma | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Headaches | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Trouble | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hepatitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| HIV/AIDS | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Neck Pain | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Prolonged Bleeding | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thyroid disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tuberculosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

DENTAL HISTORY

Patient's Dentist _____

Date of last dental examination _____

Has the patient experienced:

Thumb/Finger Sucking Yes No

Tongue thrusting Yes No

Popping/Clicking/Pain of jaw joint Yes No

Mouth breathing Yes No

Teeth grinding/clenching Yes No

Missing or extra permanent teeth Yes No

Ear Infections Yes No

Gum disease Yes No

Have any permanent teeth been injured by a fall or blow? Yes No

Have tonsils and adenoids been removed? Yes No

Have any primary or permanent teeth been extracted? Yes No

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

Signature (Parent's signature if minor) _____

CONFIDENTIAL (for record and pretreatment evaluation)

Thank you for supplying the above information