DATE:

LEANNE MAZZEI, D.D.S.

ORTHODONTIC MEDICAL AND DENTAL QUESTIONNAIRE

(PLEASE COMPLETE AND BRING TO APPOINTMENT)

PATIENT / GENERAL INFORMATION

PATIENT'S FULL NAME LAST	FIRST	MIDDLE	NICKNAME
DATE OF BIRTH	AGE	SEX ☐ M ☐ F	
PATIENT'S ADDRESS (STREET)			
CITY	ZIP		
PATIENT'S PHONE ( )	GRADE IN SCHOOL		
PATIENT'S SCHOOL			

BROTHERS/SISTERS (NAMES & BIRTHDATES)	DATE OF BIRTH
BROTHERS	
SISTERS	

If yes, please give details.

DOES HE/SHE FREQUENTLY PARTICIPATE IN CONTACT SPORTS? ______

PLAY A MUSICAL INSTRUMENT? ______

WHAT ARE MAIN EXTRACURRICULAR ACTIVITIES OR INTERESTS? ______

PATIENT'S FATHER

NAME LAST	FIRST	MIDDLE	MARITAL STATUS MARRIED DIVORCED SEPARATED WIDOWED
RESIDENCE (IF DIFFERENT FROM PATIENT) STREET	CITY	STATE	ZIP
HOW LONG AT THIS ADDRESS	HOME PHONE ( )	WORK PHONE ( )	
PREVIOUS ADDRESS (IF LESS THAN 1 YEAR) STREET	CITY	STATE	ZIP
SOCIAL SECURITY #	BIRTHDATE		
OCCUPATION	EMPLOYER	# OF YEARS EMPLOYED	

PATIENT'S MOTHER

NAME LAST	FIRST	MIDDLE	MARITAL STATUS MARRIED DIVORCED SEPARATED WIDOWED
RESIDENCE (IF DIFFERENT FROM PATIENT) STREET	CITY	STATE	ZIP
HOW LONG AT THIS ADDRESS	HOME PHONE ( )	WORK PHONE ( )	
PREVIOUS ADDRESS (IF LESS THAN 1 YEAR) STREET	CITY	STATE	ZIP
SOCIAL SECURITY #	BIRTHDATE		
OCCUPATION	EMPLOYER	# OF YEARS EMPLOYED	

RESPONSIBLE PARTY INFORMATION (If Other Than Above)

NAME LAST	FIRST	MIDDLE	MARITAL STATUS MARRIED DIVORCED SEPARATED WIDOWED
RESIDENCE STREET	CITY	STATE	ZIP
HOW LONG AT THIS ADDRESS	HOME PHONE ( )	WORK PHONE ( )	
PREVIOUS ADDRESS (IF LESS THAN 1 YR.) STREET	CITY	STATE	ZIP
SOCIAL SECURITY #	BIRTHDATE	RELATIONSHIP TO PATIENT	
OCCUPATION	EMPLOYER	# OF YEARS EMPLOYED	

We offer budgeted payment plans; therefore, our office reviews credit bureau information.

PATIENT DENTAL HISTORY

PATIENT'S DENTIST	PHONE NUMBER ( )
WHEN WAS THE LAST DENTAL CHECK UP?	APPROXIMATE DATE OF LAST DENTAL X-RAY TAKEN

WHAT IS PATIENT'S ORTHODONTIC PROBLEM AS YOU SEE IT?

HAS THE PATIENT BEEN EXAMINED BY AN ORTHODONTIST BEFORE? IF YES, WHEN?

ANY BLOW OR INJURY TO THE FACE OR TEETH?

ANY THUMB SUCKING?	TOOTH CLENCHING OR GRINDING (AT NIGHT?)	OTHER HABITS?

(EXPLAIN)

ANY CLICKING OR PAIN WHEN HE/SHE OPENS OR CLOSES HIS/HER MOUTH?

REFERRAL INFORMATION

WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

AREA OR ADDRESS (IF AVAILABLE)

NAMES OF CLOSE FRIENDS OR RELATIVES THAT ARE PATIENTS OF THIS PRACTICE

PATIENT MEDICAL HISTORY

PATIENT'S PHYSICIAN	PHONE NUMBER ( )

HOW IS PATIENT'S GENERAL HEALTH?

IS THE PATIENT NOW UNDER A PHYSICIAN'S CARE? IF YES, FOR WHAT REASON?

IS THE PATIENT TAKING ANY MEDICATION AT PRESENT?	HAVE MEDICAL X-RAYS BEEN TAKEN IN THE PAST YEAR?

DOES THE PATIENT HAVE:

ANY DIFFICULTY IN BREATHING THROUGH NOSE? __________ ANY DIFFICULTY IN SWALLOWING OR CHEWING?

☐ DIABETES? ☐ ASTHMA? ☐ RHEUMATIC FEVER? ☐ CONVULSIONS? ☐ ANY CONTAGIOUS DISEASES?

IS THE PATIENT ALLERGIC TO ANYTHING? (FOOD, DRUGS, ETC.) __________

DOES THE PATIENT NEED TO BE **PREMEDICATED** FOR ANY REASON? __________

ARE THE PATIENT'S TONSILS AND ADENOIDS PRESENT? __________

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO	WHO IS THE PRIMARY INSURANCE CARRIER? ☐ FATHER ☐ MOTHER ☐ OTHER ______

INSURANCE COMPANY

INSURANCE ADDRESS STREET	CITY	STATE	ZIP	PHONE ( )

GROUP NUMBER	POLICY NUMBER	LOCAL NUMBER	UNION NUMBER	CLAIM NUMBER

SIGNATURE ____________________