LEANNE MAZZEI, D.D.S.

ORTHODONTIC MEDICAL AND DENTAL QUESTIONNAIRE

DATE:

(PLEASE COMPLETE AND BRING TO APPOINTMENT)

PATIENT INFORMATION

NAME DR ☐ MR. ☐ MISS ☐ MRS ☐ LAST	FIRST	MIDDLE	MARITAL STATUS PLEASE CIRCLE MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED ☐ WIDOWED ☐	
RESIDENCE STREET	CITY		STATE	ZIP
HOME PHONE ( )	CELL PHONE ( )		WORK PHONE ( )	
E-MAIL ADDRESS	PLEASE INDICATE METHODS OF COMMUNICATION FROM OUR OFFICE. HOME (☐) CELL (☐) WORK (☐) E-MAIL (☐)			
SOCIAL SECURITY #	BIRTHDATE	AGE	HOBBIES/INTERESTS	
OCCUPATION	EMPLOYER	# OF YEARS EMPLOYED		
SPOUSE'S NAME LAST	FIRST	MIDDLE	CHILDREN (NAMES / BIRTHDATES)	
OCCUPATION	EMPLOYER	# OF YEARS EMPLOYED		
WORK PHONE ( )	SOCIAL SECURITY #	BIRTHDATE		

RESPONSIBLE PARTY INFORMATION (If Other Than Above)

NAME LAST	FIRST	MIDDLE	MARITAL STATUS PLEASE CIRCLE 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.

REFERRAL SOURCE

WHOM 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

INSURANCE INFORMATION

If you have any type of dental insurance, please complete the following. If not, turn the page.

NAME OF INSURANCE CARRIER	NAME OF GROUP PLAN	GROUP NUMBER
ADDRESS		PHONE ( )
EMPLOYEE		EMPLOYEE SOCIAL SECURITY NUMBER
PATIENT'S RELATIONSHIP TO EMPLOYEE		
EMPLOYER		
ADDRESS (STREET, CITY, STATE, ZIP)		TELEPHONE ( )
UNION LOCAL NUMBER (ADDRESS)		
IS THE PATIENT COVERED BY ANOTHER PLAN?	IF SO, NAME OF PLAN	
EMPLOYER OF PERSON HOLDING POLICY (STREET, CITY, STATE, ZIP)		TELEPHONE ( )

SIGNATURE _____

DENTAL HISTORY

DENTIST
LAST FIRST

SPECIALTY

ADDRESS (STREET)

(City, State, Zip)

PHONE
( )

PERIOD OF TREATMENT

OTHER DENTIST

SPECIALTY

ADDRESS (STREET)

(City, State, Zip)

PHONE
( )

PERIOD OF TREATMENT

DATE OF LAST DENTAL VISIT _____

DATE OF LAST FULL-MOUTH X-RAY _____

DATE OF LAST COMPLETED DENTAL EXAMINATION _____

WHAT IS YOUR IMMEDIATE DENTAL AND ORTHODONTIC CONCERN AS YOU SEE IT? _____

YES	NO	
○	○	ARE YOU PRESENTLY IN ANY DENTAL PAIN?
○	○	DO YOU HAVE ANY GROWTHS OR SWELLINGS IN YOUR MOUTH? HOW LONG HAVE THEY EXISTED?
○	○	DO YOU HAVE DIFFICULTY SWALLOWING?
○	○	DO YOUR GUMS BLEED WHEN YOU BRUSH YOUR MOUTH?
●	○	DO YOU AVOID BRUSHING ANY PART OF YOUR MOUTH, WHY?
○	○	DOES FOOD CATCH BETWEEN YOUR TEETH?
○	○	HAVE YOU EVER BEEN TOLD YOU HAVE GUM DISEASE?
○	○	IS ANY PART OF YOUR MOUTH SENSITIVE TO TEMPERATURE, PRESSURE, FOOD OR DRINK?
○	○	DO YOU HAVE A BURNING SENSATION IN YOUR MOUTH?
○	○	DO YOU HAVE ANY UNPLEASANT TASTE OR ODOR IN YOUR MOUTH?

Please check yes or no: If yes, Please explain.

YES	NO	
○	○	HAVE YOU EVER HAD ORTHODONTIC TREATMENT WHEN? _____
○	○	ARE YOU DISSATISFIED WITH YOUR TEETH AND THEIR APPEARANCE? EXPLAIN _____
○	○	HAVE YOU EVER HAD A BAD REACTION TO A DENTAL? ANESTHETIC? WHEN? _____
○	○	HAVE YOU EVER EXPERIENCED ANY UNFAVORABLE REACTION TO DENTISTRY? _____

YES	NO	
○	○	HAVE YOU BEEN PREVIOUSLY DIAGNOSED AS HAVING A JAW JOINT CONDITION? _____
○	○	ARE YOU AWARE OF GRINDING YOUR TEETH DURING YOUR SLEEP? HOW OFTEN _____
○	○	DO YOU HAVE DIFFICULTY OPENING YOUR MOUTH WIDELY?
○	○	DO YOU HAVE ANY PAIN OR SORENESS AROUND YOUR EYES OR EARS OR OTHER PARTS OF YOUR FACE? _____
○	○	DO YOU HAVE "TENSION" HEADACHES? HOW OFTEN?
○	○	ARE YOU AWARE OF STIFF NECK MUSCLES? HOW OFTEN?
○	○	ARE YOU AWARE OF CLENCHING YOUR TEETH DURING YOUR DAYTIME HOURS? HOW OFTEN? _____
○	○	ARE YOU AWARE OF YOUR JAW CLICKING OR POPPING WHILE EATING OR YAWNING? HOW OFTEN? _____

MEDICAL HISTORY

PATIENT: HEIGHT	WEIGHT	DATE OF LAST COMPLETE MEDICAL EXAMINATION
FAMILY PHYSICIAN	SPECIALTY	
ADDRESS (Street, City, State, Zip)		TELEPHONE ( )
ADDITIONAL PHYSICIAN	SPECIALTY	
ADDRESS (Street, City, State, Zip)		TELEPHONE ( )

Please check yes or no: If yes, please give details.

YES NO

- ○ ○ DO YOU **PREMEDICATE** FOR ANY REASON? _____
- ○ ○ DO YOU HAVE A CURRENT MEDICAL PROBLEM? WHAT? _____
- ○ ○ HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY INFECTIOUS DISEASES SUCH AS TUBERCULOSIS, HEPATITIS OR AIDS? _____
- ○ ○ DO YOU HAVE HIGH OR LOW BLOOD PRESSURE? IS IT CONTROLLED? _____
- ○ ○ HAVE YOU HAD PAINS IN THE CHEST OR SHORTNESS OF BREATH? _____
- ○ ○ DO YOUR ANKLES EVER SWELL? _____
- ○ ○ HAS YOUR PHYSICIAN EVER TOLD YOU THAT YOU ARE ANEMIC? _____
- ○ ○ HAVE YOU EVER HAD A STROKE? WHEN? _____
- ○ ○ HAVE YOU EVER HAD DIABETES? HOW IS IT CONTROLLED? _____
- ○ ○ ARE YOU SUBJECT TO FAINTING OR DIZZINESS? WHEN? _____
- ○ ○ DO YOU HAVE HEADACHES? HOW OFTEN? _____
- ○ ○ DO YOU HAVE PROBLEMS WITH INSOMNIA? HOW OFTEN? _____
- ○ ○ DO YOU HAVE ANY NERVOUS DISORDER? HOW IS IT CONTROLLED? _____
- ○ ○ DO YOU TAKE TRANQUILIZERS OR SEDATIVES? HOW OFTEN? _____
- ○ ○ DO YOU TAKE ASPIRIN? HOW OFTEN? _____
- ○ ○ ARE YOU ALLERGIC TO ANY MEDICATIONS? WHAT? _____
- ○ ○ HAVE YOU BEEN ADVISED NOT TO TAKE ANY MEDICATIONS? WHAT? _____
- ○ ○ DO YOU HAVE ASTHMA OR HAY FEVER? HOW IS IT CONTROLLED? _____
- ○ ○ DO YOU HAVE ARTHRITIS? HOW IS IT CONTROLLED? _____
- ○ ○ HAVE YOU EVER HAD A TUMOR OR CANCER? HOW WAS IT TREATED? _____
- ○ ○ HAVE YOU HAD ANY MAJOR OPERATIONS? WHAT KIND? _____
- ○ ○ HAVE YOU EVER BEEN INVOLVED IN A SERIOUS ACCIDENT? _____
- ○ ○ ARE YOU TAKING ANY MEDICATION? PLEASE LIST:

TAKING _____ FOR _____ TAKING _____ FOR _____

TAKING _____ FOR _____ TAKING _____ FOR _____

TAKING _____ FOR _____ TAKING _____ FOR _____

- ○ ○ HAVE YOU GAINED OR LOST WEIGHT WITHIN THE LAST YEAR? HOW MUCH? _____
- ○ ○ DO YOU BECOME FATIGUED EASILY? AT WHAT TIME OF DAY? _____
- ○ ○ DO YOU FREQUENTLY NOT EAT BREAKFAST? _____
- ○ ○ DO YOU HAVE MORE THAN ONE ALCOHOLIC DRINK PER DAY? HOW MANY? _____
- ○ ○ DO YOU USE TOBACCO? HOW MUCH? _____
- ○ ○ IS YOUR DIET MEDICALLY SUPERVISED? FOR WHAT PURPOSE? _____

FOR WOMEN

- ○ ○ ARE YOU PREGNANT? EXPECTED DELIVERY DATE _____
- ○ ○ HAVE YOU REACHED MENOPAUSE? IF SO, ARE YOU TAKING SUPPORTIVE MEDICATION? _____

PATIENT NOTES

Submit