

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

PATIENT'S MOTHER

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

RESPONSIBLE PARTY INFORMATION (If Other Than Above)

NAME			MARITAL STATUS	
LAST	FIRST	MIDDLE	MARRIED	DIVORCED
RESIDENCE			SEPARATED	WIDOWED
STREET		CITY	STATE	ZIP
HOW LONG AT THIS ADDRESS		HOME PHONE ()	WORK PHONE ()	
PREVIOUS ADDRESS (IF LESS THAN 1 YR.)		CITY	STATE	ZIP
STREET				
SOCIAL SECURITY #			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?	
<i>DOES THE PATIENT HAVE:</i>			
ANY DIFFICULTY IN BREATHING THROUGH NOSE?		ANY DIFFICULTY IN SWALLOWING OR CHEWING?	
<input type="checkbox"/> DIABETES?	<input type="checkbox"/> ASTHMA?	<input type="checkbox"/> RHEUMATIC FEVER?	<input type="checkbox"/> CONVULSIONS?
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHO IS THE PRIMARY INSURANCE CARRIER? <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> OTHER		
INSURANCE COMPANY				
INSURANCE ADDRESS	STREET	CITY	STATE	ZIP
				PHONE ()
GROUP NUMBER	POLICY NUMBER	LOCAL NUMBER	UNION NUMBER	CLAIM NUMBER

SIGNATURE _____