Rothenberg Orthodontics - New Patient Questionnaire

Date: _____

Patient's Name: _____ Nickname: _____

Date of Birth: _____ Home Phone: _____

Home Address: _____

Patient's General/Pediatric Dentist: _____

Whom may with thank for referring you to our office? _____

Patient's Interests (sports, hobbies, musical instruments, etc):

_____

_____

Brother's age(s): _____ Sister's age(s): _____

Mother/Father's Name: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

Mother/Father's Name: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

Does the patient live with both parents? Yes No If no, with whom does the patient live? _____

Person responsible for patient account: _____

Preferred Method of Contact (circle one):

Home Phone Mother's Cell Father's Cell

Mother's Email Address Father's Email Address

If responsible party is someone other than a parent please provide the following:

Name: _____

Address: _____

Phone Number: _____ Email address: _____

Preferred Method of Contact (circle one): Phone Email

DENTAL HISTORY

Missing teeth	Extra teeth	Impacted teeth
Extraction of primary or permanent teeth	Trauma to teeth	Nail biting
Speech Issues/Therapy	Tongue thrusting	Thumb/finger sucking
Previous Orthodontic Treatment or Consultation: _____ _____ _____ _____		

TMJ HISTORY

Pain or clicking of the jaws when opening or closing		Trauma to chin or jaws
Locking of jaws	Difficulty chewing or swallowing food	Migraines/Frequent Headaches
Clenching/Grinding	Use of night guard	
Does anyone else in the family grind their teeth? Y N		
Does anyone else in the family have a history of TMJ (jaw joint) problems? Y N		

AIRWAY/SLEEP HISTORY

Snoring	Mouth breathing	Sleep Apnea
Restless sleep	Bed wetting	Excessive sweating while sleeping
Night Terrors	Sinus Problems	Seasonal Allergies
Consultation with Ears, Nose, and Throat Doctor	Removal of tonsils and/or adenoids	Bad breath
Does anyone else in the family snore or have sleep apnea? Y N		
Would you be interested in having your child do a home sleep study? Y N		

MEDICAL HISTORY

Abnormal bleeding/Hemophilia	Anemia	Sickle Cell Anemia
Antibiotics prior to dental procedures	ADHD	Anxiety
Arthritis	Asthma/Breathing Difficulty	Cancer Treatment
Congenital Heart Defects	Depression or Anxiety	Diabetes
Digestive problems such as Celiac Disease, Ulcers, Crohn's, Colitis, or Reflux		
Drug Abuse	Epilepsy/Seizures	Fever Blisters/Herpes
Heart Attack/Stroke	Heart Murmur	Heart Surgery/Pacemaker
Hepatitis/Liver Problems	High/Low Blood Pressure	HIV/AIDS
Lyme Disease/Babesia	Kidney Problems	Mitral Valve Prolapse
Psychiatric Issues	Rheumatic/Scarlet Fever	Thyroid disorder / Tuberculosis
Medical Issue not listed above:		
Girls - Has menstruation started? Y N	Boys - Has his voice changed? Y N	

ALLERGIES

Nickel	Latex	Dental Anesthetic	Penicillin, Amoxicillin, etc.
Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Naproxen (Aleve)	
Allergies not listed above:			

Please list all medications currently being taken by the patient:

_____
_____
_____

What goal(s) are you looking to accomplish with orthodontic treatment?

_____
_____
_____
_____

_____ _____

Signature of Parent or Guardian Date