Rothenberg Orthodontics - New Patient Questionnaire for Adult Patients

Date: _____

PATIENT INFORMATION

Patient's Name: _____ Nickname: _____

Date of Birth: _____ Home Phone: _____

Home Address: _____

Cell Phone: _____ Email: _____

Preferred Method of Contact (circle one): Home Phone Cell Phone Email Address

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Spouse's Name: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

Number of children in the family: _____ Names and ages: _____

_____

Person responsible for patient account: _____

If responsible party is someone other than you (the patient) please provide the following:

Name: _____

Address: _____

Phone Number: _____ Email address: _____

Patient's General/Pediatric Dentist: _____

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

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

_____

_____

_____

_____

DENTAL HISTORY

Missing teeth	Extra teeth	Impacted teeth	Trauma to teeth
Extraction of primary or permanent teeth		Nail biting	Tooth pain/sensitivity
Speech Issues/Therapy	Tongue thrusting		Thumb/finger sucking
Bleeding Gums	Periodontal Surgery/Maintenance		Food trapping between teeth
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	
Family history of TMJ (jaw joint) problems? Y N		

AIRWAY/SLEEP HISTORY

Snoring	Mouth breathing	Sleep Apnea
Restless sleep	Bad breath	Excessive sweating while sleeping
Sinus Problems	Seasonal Allergies	Asthma/Breathing Difficulty
Consultation with Ears, Nose, and Throat Doctor		Removal of tonsils and/or adenoids
Headaches upon waking up		
Family history of snoring or sleep apnea? Y N		
Would you be interested in having a home sleep study? Y N		

MEDICAL HISTORY

Antibiotics prior to dental procedures	Arthritis	Atrial Fibrillation
Bleeding Disorder (anemia, sickle cell anemia, hemophilia, etc)		
Cancer/Chemotherapy/Radiation Treatment	Congenital Heart Defects	Diabetes
Digestive problems such as Celiac Disease, Ulcers, Crohn's, Colitis, or Reflux		Drug Abuse
Epilepsy/Seizures	Fever Blisters/Herpes	Fibromyalgia
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/Behavioral Issues (ADHD, Depression, Anxiety, etc)		Rheumatic Fever
Scarlet Fever	Thyroid disorder	Tuberculosis
Medical Issue not listed above:		

IF FEMALE, ARE YOU PREGNANT OR TRYING TO GET PREGNANT: Y N

TOBACCO USAGE: Y N IF YES, FREQUENCY AND TYPE: _____

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:

_____

_____

_____

_____ _____

Signature of Patient Date