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pan orthodontics

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Health History Questionnaire

(ADULT PATIENTS)

Patient Information

Last Name _____ First _____ Middle _____

Patient prefers to be called _____ SSN _____ Birth Date _____ Age _____ ❑ Male ❑ Female

Marital Status _____ **Children:** # of Sons _____ Ages: _____ # of Daughters: _____ Ages: _____

Address _____ City _____ Zip _____

Cell Phone _____ Email _____ Home _____ Work _____

Employer _____ Position _____ Years there _____

Interests/Hobbies _____ Family/friends treated here _____

Whom may we thank for recommending us? _____

What is the primary concern for Dr. Pan to address? _____

Spouse Information (if applicable)

Last Name _____ First _____ Middle _____

SSN _____ Birth Date _____

Cell Phone _____ Email _____ Work _____

Employer _____ Position _____ Years there _____

Orthodontic Insurance Information

Primary policy holder name _____ SSN/ID# _____ Birth Date _____

Insurance company _____ Group number _____ Phone number _____

Secondary policy holder name _____ SSN/ID# _____ Birth Date _____

Insurance company _____ Group number _____ Phone number _____

Treatment Motivation

How would you describe the patient's attitude towards orthodontic treatment? _____

Please rate the following with 5 being the most important and 1 being the least.

Comfort of treatment:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	Length of treatment:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Clear or invisible treatment options:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	Latest technology for treatment:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Low down payment:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	Low monthly payments:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Starting treatment as soon as possible:	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5						

Orthodontic treatment can improve the overall appearance of a patient's teeth and face. Please help us to understand your family's wishes regarding orthodontic treatment by indicating any of the following that may apply:

How would you like the patient's teeth to change?

_____

_____

If you would like the patient's face to change, how so?

_____

_____

OVER

Dr. Yu Pan D.D.S., Ph.D

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American Association of Orthodontists®

American Board of Orthodontics

Dental History

Dentist _____ City _____ Date of last visit _____

Has patient been examined/treated by an orthodontist previously? _____

Please check any of the following if the patient has/has had:

- ❑ Injuries to the face/mouth/teeth
- ❑ Thumb, finger, or lip sucking
- ❑ Tongue thrusting
- ❑ Speech difficulties
- ❑ Missing or extra permanent teeth
- ❑ Teeth removed by extraction
- ❑ Clenching or grinding
- ❑ Other _____
- ❑ Jaw joint sounds or pain/TMJ
- ❑ Family history of jaw-size unbalance
- ❑ Previous difficulty w/dental treatment

Medical History

Physician _____ City _____ Phone _____

Medications currently being taken _____

Medication allergies_____ **Is the patient allergic to latex?** ❑ Yes ❑ No

Other allergies _____

Hospitalizations? Please list procedures and dates _____

Females: Are you pregnant or anticipating pregnancy soon? ❑ Yes ❑ No

Please check any of the following if the patient has/has had:

- ❑ Abnormal bleeding
- ❑ Anemia
- ❑ Arthritic/Rheumatoid conditions
- ❑ Artificial joints/valves/implants
- ❑ Asthma/respiratory problems
- ❑ ADHD/sensory problems
- ❑ Birth defects/hereditary issues
- ❑ Cardiovascular problems
- ❑ Cancer/tumor
- ❑ Diabetes
- ❑ Dizziness/fainting
- ❑ Ear/nose/throat/eye issues
- ❑ Eating disorders
- ❑ Endocrine/thyroid problems
- ❑ Epilepsy
- ❑ Frequent headaches
- ❑ Gastrointestinal disorders
- ❑ Heart murmur
- ❑ Hepatitis/liver problems
- ❑ Herpes
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Immune system problems
- ❑ Kidney problems
- ❑ Mental/emotional problems
- ❑ Nervous system disorders
- ❑ Radiation/chemotherapy
- ❑ Rheumatoid disorders
- ❑ Tuberculosis
- ❑ Vision/hearing problems
- ❑ Other _____

Sleep/Airway Issues

Do you tend to be a mouth-breather? ❑ Yes ❑ No

Do you feel well rested in the morning? ❑ Yes ❑ No

Are you tired or sleepy during the day? ❑ Yes ❑ No

Do you often snore at night? ❑ Yes ❑ No

Do you awaken multiple times overnight? ❑ Yes ❑ No

Has anyone observed you stop breathing, gasping or struggling to breathe while asleep? ❑ Yes ❑ No

I have read and understand the above questions. I will not hold the orthodontist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform this practice of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees, and may, at the discretion of this practice, use the services of one or more credit reporting services. If this practice accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover.

Signed _____ **Date** _____

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