Edina Office
5101 Vernon Ave South, Ste 502
Edina, MN 55436
Ph 952.926.3747

pan orthodontics

Maple Grove Office
7830 Main St, Ste 215
Maple Grove, MN 55369
Ph 952.926.3747

Health History Questionnaire

(PATIENTS UNDER 18 YEARS OLD)

Patient Information

Last Name _____ First _____ Middle _____

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

Address _____ City _____ Zip _____

Best Phone _____ Patient interests/hobbies/sports _____

Patient height _____ Sibling names/ages _____

Family/friends treated here _____ Whom may we thank for recommending us? _____

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

Father/Guardian

Last Name _____ First _____ Middle _____

Address _____ City _____ Zip _____

Years at address _____ Marital Status _____ SSN _____ Birth date _____

Relationship to patient _____ Email _____

Cell Phone _____ Home Phone _____ Work Phone _____

Employer _____ Position _____ Years there _____

Mother/Guardian

Last Name _____ First _____ Middle _____

Address _____ City _____ Zip _____

Years at address _____ Marital Status _____ SSN _____ Birth date _____

Relationship to patient _____ Email _____

Cell Phone _____ Home Phone _____ Work Phone _____

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						

OVER

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

www.panorthodontics.com

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 ❑ Missing or extra permanent teeth ❑ Jaw joint sounds or pain/TMJ

❑ Thumb, finger, or lip sucking ❑ Teeth removed by extraction ❑ Family history of jaw-size unbalance

❑ Tongue thrusting ❑ Clenching or grinding ❑ Previous difficulty w/dental treatment

❑ Speech difficulties ❑ Other _____

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: Has menstruation began? ❑ Yes ❑ No If so, when?_____ Is the patient pregnant? ❑ Yes ❑ No

Has the patient had any recent rapid growth? ❑ Yes ❑ No If so, how much? _____

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

❑ Abnormal bleeding ❑ Cancer/tumor ❑ Gastrointestinal disorders ❑ Mental/emotional problems

❑ Anemia ❑ Diabetes ❑ Heart murmur ❑ Nervous system disorders

❑ Arthritic/Rheumatoid conditions ❑ Dizziness/fainting ❑ Hepatitis/liver problems ❑ Radiation/chemotherapy

❑ Artificial joints/valves/implants ❑ Ear/nose/throat/eye issues ❑ Herpes ❑ Rheumatoid disorders

❑ Asthma/respiratory problems ❑ Eating disorders ❑ High blood pressure ❑ Tuberculosis

❑ ADHD/sensory problems ❑ Endocrine/thyroid problems ❑ HIV/AIDS ❑ Vision/hearing problems

❑ Birth defects/hereditary issues ❑ Epilepsy ❑ Immune system problems ❑ Other _____

❑ Cardiovascular problems ❑ Frequent headaches ❑ Kidney problems _____

Sleep/Airway Issues

Does the patient tend to be a mouth-breather? ❑ Yes ❑ No Does the patient often snore at night? ❑ Yes ❑ No

Does the patient seem rested in the morning? ❑ Yes ❑ No Does the patient sleep-walk or have night terrors? ❑ Yes ❑ No

Is the patient often sleepy during the day? ❑ Yes ❑ No Has the patient seen an Ear, Nose & Throat specialist? ❑ 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 child's medical status. I authorize the dental staff to perform the necessary dental services my child 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 (parent/guardian) _____ **Date** _____

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