FORWOOD & CHRISTIE ORTHODONTICS, P.C.

PRACTICE LIMITED TO ORTHODONTICS FOR CHILDREN AND ADULTS

HEALTH QUESTIONNAIRE

Please note that if the form is being completed by a parent or guardian, all questions below pertain to the patient, and not the parent or guardian.

Date: _____ Patient's Name :_____ Date of Birth: _____

Male ___ Female____Patient's Marital Status : Single _____ Married _____ Divorced _____ Widowed ____

Occupation / School : _____ Grade : _____

Parent or Guardian(If patient is a minor): _____

Address: _____ Zip : _____

Patient Home Phone : _____ Cell Phone : _____
(Parent / Adult Patient)

Work Phone : _____ Email Address: _____
(Parent / Adult Patient) (Parent / Adult Patient)

SECTION A

Medical Doctor's Name and Address: _____

_____ Date of Last Visit: _____

Dentist's Name and Address : _____

_____

Date of Last Visit : _____ Date of Last Dental X-Rays :_____

Major dental problem or reason for seeking treatment : _____

_____

SECTION B

Answer all questions by circling "YES" or "NO" and fill in all blank spaces when indicated.

1. NO YES Has there been any change in your general health within the past year?
2. NO YES Are you now under the care of a physician? If yes, what is the condition being treated?

   _____
3. NO YES Have you been hospitalized or had a serious illness during the past 5 years? If yes, what was the problem? _____

SECTION C MEDICAL HISTORY

1. NO YES Rheumatic fever or rheumatic heart disease?
2. NO YES Heart murmur or congenital heart disease?
3. NO YES Heart trouble, heart attack, stroke, pacemaker, or prosthetic (artificial) heart valve?
4. NO YES Do you need to be premedicated with antibiotics for dental procedures, cleanings, etc?
5. NO YES Shortness of breath or chest pain after mild exercise?
6. NO YES Shortness of breath when you lie down?
7. NO YES Do you use more than two pillows to sleep?
8. NO YES High blood pressure?
9. NO YES Do your ankles swell?
10. NO YES Asthma, Emphysema, or difficulty breathing?
11. NO YES Seizures or convulsions?
12. NO YES Diabetes?
13. NO YES A loss or gain of 10 pounds or more in the last year?
14. NO YES Frequent urination (pass water more than six times a day)?
15. NO YES Excessive thirst?
16. NO YES Hepatitis, jaundice, or liver disease?
17. NO YES Have you ever tested positive for HIV?
18. NO YES Do you have reason to believe that you are at risk of being HIV positive?
19. NO YES Arthritis?
20. NO YES Cancer / Chemotherapy?
21. NO YES Stomach ulcers?
22. NO YES Kidney trouble or renal dialysis?
23. NO YES Tuberculosis?
24. NO YES A persistent cough or coughing up blood?
25. NO YES Venereal disease, gonorrhea, syphilis, (bad blood)?
26. NO YES Psychiatric therapy?
27. NO YES Thyroid disease?
28. NO YES Have you had surgery or radiation treatment (x-ray) treatment for a tumor, growth, cancer, or other condition of your head, neck or mouth?
29. NO YES Do you bleed excessively after you are cut?
30. NO YES Have you ever required a blood transfusion?
31. NO YES Have you ever been denied permission to give blood?
32. NO YES Do you have any hearing, visual problems, or other disabilities which we should consider in planning your dental treatment (e.g. glaucoma)?
33. NO YES Have you ever been in contact with any individual having hepatitis, tuberculosis, or AIDS?
34. NO YES Are you addicted or recovering from any drugs or alcohol?
35. NO YES If patient is a child, has he / she reached puberty?

SECTION D HAVE YOU TAKEN ANY OF THE FOLLOWING DRUGS OR MEDICATIONS IN THE PAST 6 MONTHS?

1. NO YES Anticoagulants (blood thinners), or aspirin?
2. NO YES Medicine for high blood pressure or water pills?
3. NO YES Cortisone (steroids)?
4. NO YES Valium, Librium, or tranquilizers?
5. NO YES Ritalin, Adderall or similar type medications?
6. NO YES Growth hormone?
7. NO YES Insulin or pills for diabetes?
8. NO YES Digitalis or drugs for heart trouble?
9. NO YES Nitroglycerin or other medication for angina pectoris (chest or heart pain)?
10. NO YES Dilantin?
11. NO YES Medicine not prescribed by an M.D. (i.e. patent medicine)?
12. NO YES Osteoporosis medication (such as Boniva, Fosamax, Actonel, Reclast) ?
13. NO YES All Other medications: _____

SECTION E **ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION SUCH AS ITCHING, RASH,SWELLING OF HANDS, FEET OR EYES TO :**

1. NO YES Novocaine or dental anesthetic?
2. NO YES Penicillin or other antibiotics? – What antibiotic? _____
3. NO YES Aspirin?
4. NO YES Codeine or other narcotics?
5. NO YES Other (Metals/ Nickel)_____

SECTION F **WOMEN ONLY OTHERWISE PROCEED TO SECTION G**

1. NO YES Are you pregnant or anticipating being pregnant in the near future?
2. NO YES Are you taking birth control pills or hormones?

SECTION G **ORAL HEALTH**

1. In your own words please describe the orthodontic problem as you see it: _____
   _____
2. Does anyone in the family have a strong lower jaw or similar dental or facial condition? YES _____ NO _____
   If yes describe: _____
3. Have you or anyone in the family received orthodontic care? YES _____ NO _____
4. Have you consulted an orthodontist previously? YES _____ NO _____
5. By whom were you directly referred? _____
   _____
6. Have you been pleased with your previous dental care? YES _____ NO _____
   If no please comment: _____
   _____
7. NO YES Is there a history of fever blisters or cold sores?
8. NO YES Is there a history of recurrent canker sores, mouth ulcers, or herpes infections?
9. NO YES Has there been any trouble with any previous dental treatment?
10. NO YES Have there been problems with bleeding excessively from after extractions, surgery, or wounds?
11. NO YES Have there been any problems with a dry mouth frequently?
12. NO YES Is there any disease or condition, or problem not listed?
    If yes please specify : _____
    _____
13. NO YES Is there a history of jaw joint pain, or any clicking or popping in jaw joint?
    If yes please explain : _____
14. What is the usual reason for visiting the dentist?
    Routine checkup and cleaning _____
    Only when there is a dental problem _____
15. NO YES Are you aware of any oral habits such as lip sucking, grinding, nail biting, or chewing on foreign objects such as pencils?
16. NO YES Have the teeth or jaws ever been injured in an accident? When _____
17. NO YES Are you aware of any teeth missing since birth?
18. NO YES Have you ever been told that you have gum disease?
19. NO YES Have you ever had orthodontic treatment before?

SECTION H **SOCIAL HISTORY (Patient)**

1. NO YES Do you smoke? What? _____ How many / day? _____ How many years? _____
2. NO YES Do you drink alcoholic beverages? What ? _____
   How much / day? _____ How many years? _____

SECTION I **FAMILY HISTORY**

1. NO YES Do you have a family history of heart disease, diabetes, arthritis, bleeding, anemia, or immunological diseases such as lupus?
2. NO YES Do you have any family history of muscular or brain disorders?

(OVER)

DENTAL INSURANCE INFORMATION (WE DO **NOT** NEED YOUR MEDICAL INSURANCE INFORMATION)

Insured's Name _____ Policy Holder Date of Birth _____
(Name of Policy Holder)

Insurance Co. _____ Insurance Co. Address _____

Insurance Co. Phone Number _____ Insured's Employer _____

Employer Address _____ Insured's Social Security # _____

Group No. _____ Identification No. _____

IF YOU HAVE DUAL DENTAL INSURANCE COVERAGE :

Insured's Name _____ Policy Holder Date of Birth _____
(Name of Policy Holder)

Insurance Co. _____ Insurance Co. Address _____

Insurance Co. Phone Number _____ Insured's Employer _____

Employer Address _____ Insured's Social Security # _____

Group No. _____ Identification No. _____

Flex Spending _____YES _____NO

I will do everything necessary to assist the office of Forwood & Christie Orthodontics in receiving the credited insurance benefits, if any, by completing and submitting any necessary forms, as well as communicating all and any change in my insurance benefit. I am aware that I, not my insurance company, am responsible for all balances on the account, whether or not the insurance company pays the full expected benefit allowance. In addition, this will serve as signature on file for the submission of all insurance claims and assignment of benefit to the above named office.

_____ _____ _____ _____

Release of Information Signature of Patient or Parent if Minor — Date — Authorize Payment directly To Dentist Insured — Date

The medical information provided is complete to the best of my knowledge. I agree to inform this office of any change(s) in patient's health or changes in medications. In addition, I authorize Forwood & Christie Orthodontics, P.C. to render dental treatment.

Health questionnaire completed by (Print) _____

Date _____

Signature _____
(Parent or guardian if patient is a minor)

Members American Association of Orthodontists