# Questionnaire

## PC - Welcome Information - Adult

Adult Information Sheet

WELCOME TO PARK CITIES ORTHODONTICS

PLEASE FILL IN EACH OF THE FOLLOWING BOXES WITH THE CORRECT INFORMATION

THIS FORM IS HIPAA COMPLIANT TO ENSURE PRIVACY

### PATIENT INFORMATION

PATIENT'S FIRST NAME: _____ LAST NAME:_____
PATIENT'S PREFERRED NAME: _____ SEX: FEMALE MALE
DATE OF BIRTH: _____ AGE IN YEARS: _____
PATIENT'S CELL PHONE: _____ PATIENT'S HOME PHONE: _____
PATIENT'S EMAIL: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
I PREFER OFFICE COMMUNICATION VIA? TEXT EMAIL BOTH
LIST NAME AND BIRTHDATE OF CHILDREN
NAME: _____ BIRTHDATE: _____
NAME: _____ BIRTHDATE: _____
HOBBIES/SPORTS/ACTIVITIES/MUSICAL INSTRUMENTS? _____
HAS PATIENT EVER BEEN SEEN FOR ANY OTHER ORTHODONTIC CONSULTATION? _____
IF YES - ORTHODONTIST NAME: _____ DATE OF VISIT: _____
HAS PATIENT EVER HAD PREVIOUS ORTHODONTIC TREATMENT?_____
IF YES - ORTHODONTIST NAME: _____ HOW LONG AGO WAS TREATMENT?_____

### RESPONSIBLE PARTY INFORMATION

(Please complete if different than Patient)

FIRST NAME: _____ LAST NAME: _____
DATE OF BIRTH: _____ SOCIAL SECURITY: _____
EMPLOYED BY:_____ OCCUPATION: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____
WHICH PHONE # IS THE BEST TO REACH RESPONSIBLE PARTY AT? CELL HOME WORK
EMAIL ADDRESS: _____

### SPOUSE'S INFORMATION

SPOUSE'S FIRST NAME: _____ SPOUSE'S LAST NAME: _____
DATE OF BIRTH: _____ SOCIAL SECURITY: _____
SPOUSE IS EMPLOYED BY:_____ OCCUPATION: _____
SPOUSE'S HOME PHONE: _____ SPOUSE'S WORK PHONE: _____
SPOUSE'S CELL PHONE: _____
WHICH IS THE BEST PHONE # TO REACH SPOUSE AT? CELL HOME WORK
SPOUSE'S EMAIL ADDRESS: _____
MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPERATED
CUSTODIAL PARENT

### EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ PHONE: _____
PHYSICIAN NAME: _____ PHONE: _____

### REFERRAL INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
DENTIST FAMILY FRIENDS DRIVE BY WEBSITE OTHER: _____
YOUR REFERRAL'S NAME (FIRST AND LAST):_____
HAS ANYONE IN YOUR FAMILY HAD ORTHODONTIC TREATMENT IN OUR OFFICE? YES NO
IF YES...WHO? (FIRST/LAST NAMES AND RELATIONSHIP TO PATIENT): _____

### PRIMARY INSURED INFORMATION

NAME OF PRIMARY INSURED* (As it appears on the insurance card): _____
PRIMARY INSURED'S DATE OF BIRTH: _____
PRIMARY INSURED'S SSN / MEMBER ID#: _____
PRIMARY INSURED'S RELATIONSHIP TO PATIENT: MOM DAD GUARDIAN STEPMOM STEPDAD GRANDPARENT
STREET ADDRESS OF THE INSURED:_____
CITY:_____ STATE: _____ ZIP: _____

PRIMARY INSURED'S EMPLOYER: _____
NAME OF PRIMARY DENTAL INSURANCE COMPANY: _____
PRIMARY INSURANCE GROUP: _____
PRIMARY INSURANCE COMPANY'S STREET ADDRESS: _____
PRIMARY INSURANCE CITY: _____ PRIMARY INSURANCE STATE: _____
PRIMARY INSURANCE ZIP: _____ PRIMARY INSURANCE COMPANY PHONE: _____

## SECONDARY INSURED INFORMATION

NAME OF SECONDARY INSURED* (As it appears on the insurance card): _____
SECONDARY INSURED'S DATE OF BIRTH: _____
SECONDARY INSURED'S SSN / MEMBER ID: _____
SECONDARY INSURED'S RELATIONSHIP TO PATIENT: MOM DAD GUARDIAN STEPMOM STEPDAD GRANDPARENT
STREET ADDRESS OF THE INSURED: _____
CITY: _____ STATE: _____ ZIP: _____
SECONDARY INSURED'S EMPLOYER:_____
NAME OF SECONDARY DENTAL INSURANCE COMPANY: _____
SECONDARY INSURANCE GROUP: _____
SECONDARY INSURANCE COMPANY'S STREET ADDRESS:_____
SECONDARY INSURANCE CITY: _____ SECONDARY INSURANCE STATE: _____
SECONDARY INSURANCE ZIP: _____ SECONDARY INSURANCE COMPANY PHONE: _____

## DENTAL HISTORY RECORD

DENTIST'S FIRST AND LAST NAME: _____ DENTIST'S PHONE:_____
DATE OF LAST DENTAL APPT: _____
ANY CURRENT DENTAL TREATMENT RECOMMENDED BY YOUR DENTIST?_____
IF YES, EXPLAIN: _____
CHECK ALL REASONS FOR SEEKING ORTHODONTIC CONSULTATION:
FRONT TEETH PROTRUDING OVERBITE / UNDERBITE CROWDED TEETH
JAW PAIN SPACES BETWEEN TEETH OTHER
DID YOUR DENTIST ENCOURAGE YOU TO SEEK AN ORTHODONTIC CONSULTATION? YES NO
HAVE YOU EVER HAD ANY DIFFICULTY WITH PAST DENTAL TREATMENT? YES NO
YOUR CURRENT DENTAL HEALTH IS? GOOD FAIR POOR
DO YOU HAVE ANY MISSING OR EXTRA TEETH? YES NO
HAVE YOU EVER BEEN TOLD THAT YOU HAVE "GUM" PROBLEMS? YES NO
HAVE YOU EVER EXPERIENCED BLEEDING GUMS/BAD TASTE OR MOUTH ODOR? YES NO
HAVE YOU EVER HAD AN INJURY TO YOUR FACE, NECK, JAWS OR TEETH? YES NO
IF YES EXPLAIN: _____
HAVE YOU EVER HAD A FRACTURED JAW / CYSTS / INFECTION? YES NO
IF YES EXPLAIN: _____
DO YOU HAVE DIFFICULTY IN CHEWING/ OPENING YOUR JAW OR RINGING IN EARS? YES NO
DO YOUR JAWS EVER CLICK OR POP? YES NO
HAVE YOU EVER HAD ANY PAIN OR TENDERNESS IN YOUR JAW JOINT? YES NO
DO YOU HAVE PRE-EXISTING TMJ PROBLEMS? YES NO
ANY SENSITIVE OR SORE TEETH? YES NO
IF YES EXPLAIN: _____
PLEASE MARK IF YOU HAVE/OR HAD ANY OF THE FOLLOWING HABITS.
NAIL BITING NIGHT GRINDING LIP BITINGTHUMB OR FINGER SUCKING PENCIL BITING MOUTHBREATHING TONGUE THRUST
OTHER: _____
ARE YOU HAPPY WITH YOUR SMILE? YES NO
ARE YOU INTERESTED IN: TRADITIONAL (metal) BRACES CLEAR (ceramic) BRACES INVISALIGN RETAINERS

## MEDICAL HISTORY RECORD

Your health is important to us. In order to provide excellent care with safety, it is necessary to become acquainted with vital information related to each patient. Thus, it is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask the doctor or a member of the staff for assistance.

HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST 2 YEARS? YES NO
HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN THE PAST 2 YEARS? YES NO
HAVE YOU TAKEN ANY KIND OF MEDICINE OR DRUGS DURING THE PAST YEAR? YES NO
ARE YOU CURRENTLY TAKING/OR HAVE YOU EVER TAKEN ORAL OR INTRAVENOUS BISPHOSPHONATES FOR SERIOUS BONE DISORDERS/CANCERS, SUCH AS ZOMETA (ALENDRONATE), AREDIA (PARMIDRONATE), DIDRONEL (ETODRONATE). OSTEOPOROSIS, OSTEOPENIA, FOSAMAX, (ALENDRONATE), ACTONEL (RISENDRONATE), BONIVA (IBANDRONATE), SKELID (TILUDRONATE)? YES NO
If yes, describe: _____

PLEASE LIST THE MEDICATIONS:_____

DO YOU SMOKE? YES - How Much?_____ NO

WOMEN: ARE YOU PREGNANT / IS THERE A POSSIBILITY YOU ARE PREGNANT? YES - NO HOW MANY MONTHS?_____

DO YOU SUFFER FROM FREQUENT OR SEVERE HEADACHES, NECK OR BACK PAIN? YES NO

IF YES EXPLAIN: _____

HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES? YES NO

IF YES EXPLAIN: _____

Have you ever had any of the following diseases or medical problems. Please mark YES or NO .

| | | | |
|---|---|---|---|
| **HEMOPHILIA/ABNORMAL BLEEDING:** | YES NO | **ANEMIA:** | YES NO |
| **ASTHMA:** | YES NO | **AIDS / HIV+:** | YES NO |
| **ARTHRITIS:** | YES NO | **AUTISM/ASPERGERS:** | YES NO |
| **CANCER / CHEMOTHERAPY/RADIATION:** | YES NO | **DIABETES:** | YES NO |
| **DRUG / ALCOHOL ABUSE:** | YES NO | **EPILEPSY / SEIZURES / FAINTING:** | YES NO |
| **FIBROMYALGIA:** | YES NO | **HEARING IMPAIRMENT:** | YES NO |
| **HEART ATTACK / STROKE:** | YES NO | **HEART MURMUR/HEART DISEASE:** | YES NO |
| **HEART SURGERIES/HEART PACEMAKER:** | YES NO | **HEPATITIS:** | YES NO |
| **HIGH / LOW BLOOD PRESSURE:** | YES NO | **KIDNEY PROBLEMS:** | YES NO |
| **MITRAL VALVE PROLAPSE:** | YES NO | **RHEUMATIC / SCARLET FEVER:** | YES NO |
| **PAIN/PRESSURE/TIGHTNESS IN CHEST:** | YES NO | **PSYCHIATRIC/LEARNING/ADHD:** | YES NO |
| **SINUS/BREATHING PROBLEMS:** | YES NO | **SPEECH PROBLEMS:** | YES NO |
| **TONSILS/ADENOIDS REMOVED:** | YES NO | **TUBERCULOSIS:** | YES NO |

ANY MAJOR OPERATIONS?: YES NO IF YES EXPLAIN: _____

IS ANTIBIOTIC PREMEDICATION REQUIRED BEFORE DENTAL PROCEDURES?: YES NO EXPLAIN: _____

ARE YOU ALLERGIC TO :

Please mark YES or NO for the following allergies

| | | | | | |
|---|---|---|---|---|---|
| **ANY METALS/PLASTICS:** | YES NO | **CODEINE:** | YES NO | **DENTAL ANESTHETICS:** | YES NO |
| **UNKNOWN LATEX:** | YES NO | **PENICILLIN:** | YES NO | **TETRACYCLINE:** | YES NO |

**LIST ANY OTHER ALLERGIES**: _____

NOW OR IN THE PAST, HAVE YOU HAD?

| | | | |
|---|---|---|---|
| **BIRTH DEFECT OR HEREDITARY PROBLEMS:** | YES NO | **BONE FRACTURES OR MAJOR INJURIES:** | YES NO |
| **ANY INJURIES TO THE FACE, HEAD OR NECK:** | YES NO | **MENTAL HEALTH DISTURBANCE ORDEPRESSION:** | YES NO |
| **HISTORY OF EATING DISORDERS:** | YES NO | **EXCESSIVE BLEEDING OR BRUISING, ANEMIA:** | YES NO |
| **ANGINA, ARTERIOSELEROSIS, STROKE, OR HEART ATTACK:** | | | YES NO |
| **SKIN DISORDER (OTHER THAN COMMON ACNE):** | YES NO | **FREQUENT HEADACHES OR MIGRAINS:** | YES NO |
| **FREQUENT EAR INFECTIONS, COLDS THROAT:** | YES NO | **INFECTIONS:** | YES NO |

PLEASE RATE THE FOLLOWING CONCERNS FOR THE PATIENT AND/OR RESPONSIBLE PARTY:

| | | | | |
|---|---|---|---|---|
| **Fear of Pain:** | STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE |
| **Fear of Dentists:** | STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE |
| **Trust in Dentists:** | STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE |
| **Financial Concerns:** | STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE |
| **Need for Treatment:** | STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE |

NAME OF PERSON FILLING OUT THIS FORM: _____

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE RIGHT TO REVIEW THIS OFFICE'S NOTICE OF PRIVACY PRACTICES (HIPAA). A COPY OF THIS NOTICE CAN BE VIEWED ON OUR WEBSITE WWW. PC-ORTHO.COM OR A PHYSICAL HARD COPY CAN BE OBTAINED UPON REQUEST IN OUR OFFICE. I CERTIFIED THAT I HAVE READ AND UNDERSTAND THE ABOVE. I AFFIRM THAT THE INFORMATION CONTAINED IN THIS FORM AND ANY ADDITIONAL INFORMATION THAT I MAY FURNISH IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THE ABOVE INFORMATION IS NECCESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I WILL NOT HOLD DR. TIEN NGUYEN AND OR THE STAFF OF PARK CITIES ORTHODONTICS RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.
PLEASE TYPE YOUR NAME AND DATE BELOW BEFORE SUBMITTING
OR THIS FORM WILL NOT SUBMIT TO US

PATIENT/GUARDIAN PRINTED NAME: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____