



SUPERSMILE
orthodontics

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Dear _____:

Health History Questionnaire

Thank you for selecting Dr. Chamberlain's office, where we are committed to providing you with personalized service and care beyond your expectations. At your two-hour visit you will receive a comprehensive evaluation of your orthodontic concerns.

We have enclosed this questionnaire in order to help us with your diagnosis and treatment planning. *Please complete the entire questionnaire and bring it with you to the appointment;* thank you.

A map showing the location of our offices is provided for your convenience on the back page of this questionnaire.

We are looking forward to seeing you on: Day _____, Date _____, at Time _____

Sincerely, _____ Date _____

Please provide us with the following information:

Patient's Last Name: _____, 1st _____ MI _____, Nickname: _____ Sex: M F Birth Date: _____
Address: _____ ZIP _____ Home Phone: _____ Cell Phone: _____
Years lived at above address: _____ Patient/Guardian E-mail Address: _____
School/Employer: _____ Grade/Dept. _____ Years with this Employer (if adult): _____
Marital Status (or parents marital status if a child): Married Separated Widowed Divorced (If divorced, for _____ months years)

Father/Husband: _____ Home Phone: _____ Cell Phone: _____
Address: _____
Years lived at above address: _____ (Previous address if less than 3 years: _____)
Employer: _____ Years with this Employer: _____ Dept: _____ OK to contact at office? Yes No

Mother/Wife: _____ Home Phone: _____ Cell Phone: _____
Address: _____
Years lived at above address: _____ (Previous address if less than 3 years: _____)
Employer: _____ Years with this Employer: _____ Dept: _____ OK to contact at office? Yes No

Financially Responsible Person (check off all who will be paying on this account): Patient Father Mother Other (complete below *ONLY* if Other)
Other Name: _____ Relation To Pt.: _____ Soc. Sec. No.: _____
Address: _____ Home Phone: _____ Work Phone: _____
Years lived at above address: _____ (Previous address if less than 3 years: _____)
Employer: _____ Years with this Employer: _____ Dept: _____ OK to contact at office? Yes No

Insurance: Name of Insured: Patient Father Mother Guarantor _____
Dental Insurance? INS. Co.: _____ Group/Plan #: _____ Covers Orthodontic Treatment? Yes No ?
No INS. Co. Phone: _____ Address: _____ Guarantor's Birth Date: ____ - ____ - ____
OTHER Dental Insurance? Name of Insured: _____ Soc. Sec. No.: _____ Insured's Birth Date: ____ - ____ - ____
No INS. Co.: _____ Group/Plan #: _____ Covers TMJ Treatment? Yes No ?
No INS. Co. Phone: _____ Address: _____

In case we can't reach you, whom can we contact? Person's Name: _____ Phone: _____
Relationship to Patient: _____ Person's Address: _____

Medical History

(Please answer all Questions)

Name of Family Physician: _____ Date of last visit to physician: _____

Are there any medical specialists you see regularly? _____ Specialty: _____

Date of last time *complete physical exam*: _____ Examining doctor: _____

■ Has this patient been advised by a physician that they require an *antibiotic prior to dental treatment*? No If Yes, Antibiotic: _____ How is antibiotic given? _____

Pre-Medicates? <input type="checkbox"/> No
Rx: _____

■ This patient's general health at this time is: _____ Good, Fair, Poor Comment? _____

■ Is this patient presently under the care of a physician? _____ No, If Yes, For what? _____

■ Is this patient presently taking medications? _____ No, If Yes, which medications: _____

■ Has this patient had tonsils or adenoids removed? _____ No, If Yes, Tonsils (on date _____) Adenoids (on date _____)

■ Does this patient have a *Chronic Illness*? _____ No, If Yes, Comment? _____

■ Has this patient ever had a serious illness? _____ No, If Yes, Comment? _____

■ Has this patient ever been *Hospitalized*? _____ No, If Yes, For what? _____

■ Is this patient allergic to antibiotics (penicillin, etc)? _____ No, If Yes, which medications: _____

■ Does this patient have anesthetic reactions? _____ No, If Yes, Local General: _____

■ Is this patient allergic to anything else? _____ No, If Yes, what? Sulfa Drugs Aspirin Ibuprofen Environmental Metals

Plastics Latex Comments: _____

Allergy Alert? <input type="checkbox"/> No

■ **Does this patient now have, or ever had any of the following problems?**

- | | | |
|--|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis (type? _____) | <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Endocarditis | <input type="checkbox"/> No <input type="checkbox"/> Yes Aids or HIV Positive | <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Condition | <input type="checkbox"/> No <input type="checkbox"/> Yes Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Pacemaker | <input type="checkbox"/> No <input type="checkbox"/> Yes Lived with tuberculin person | <input type="checkbox"/> No <input type="checkbox"/> Yes Stomach Ulcers |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Angina | <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory Lung Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes Tonsillitis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Attack (coronary) | <input type="checkbox"/> No <input type="checkbox"/> Yes Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes Headaches |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Mitral Valve Prolapse | <input type="checkbox"/> No <input type="checkbox"/> Yes Alcohol Sensitivity | <input type="checkbox"/> No <input type="checkbox"/> Yes Earaches |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Congenital Heart Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes Herpes (Oral Cold Sores) | <input type="checkbox"/> No <input type="checkbox"/> Yes Jaw Pain |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Artificial Heart Valve | <input type="checkbox"/> No <input type="checkbox"/> Yes Inflammatory Rheumatism | <input type="checkbox"/> No <input type="checkbox"/> Yes Jaw Clicking (noises) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Surgery (date: _____) | <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes Attention Deficit Syndrome (ADD) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes X-Ray (radiation) cancer therapy | <input type="checkbox"/> No <input type="checkbox"/> Yes Other Emotional Problems (note below) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes Glaucoma | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Low Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes Fainting Spells | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Disorders/Bleeding Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Kidney Trouble | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes Liver Disease | |

Medical Alert? <input type="checkbox"/> No

Please comment on Yes responses: _____

■ Does this patient have any other medical problems not listed? No, If Yes, Comment: _____

Patient's Growth History: What is this patient's height? _____ Ft. _____ In. If a *BOY*, has his voice changed? No Yes
 Child's present age: _____ years, _____ months If a *GIRL*, has she started menstruation? No Yes
 Is child adopted? No Yes *MOTHER'S* present height: _____ Ft. _____ In.
 Any recent signs of increased growth? No Yes *FATHER'S* present height: _____ Ft. _____ In.
 Comments: _____

Additional Growth?
<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Possibly

Patient's Family History of: If YES, which family member _____ Comments on Family Histories: _____

<input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes	_____	_____
<input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Skin Cancer	_____	_____
<input type="checkbox"/> No <input type="checkbox"/> Yes Infectious Disease	_____	<input type="checkbox"/> TB <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV+ <input type="checkbox"/> Aids _____
<input type="checkbox"/> No <input type="checkbox"/> Yes Heart Disease	_____	_____
<input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure	_____	_____
<input type="checkbox"/> No <input type="checkbox"/> Yes Organ Disease	_____	<input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Lung _____
<input type="checkbox"/> No <input type="checkbox"/> Yes Emotional Problems	_____	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression _____
<input type="checkbox"/> No <input type="checkbox"/> Yes Stroke	_____	_____
<input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis	_____	_____

Other family history comments: _____

Medical History Reviewed: Dr.'s Initials: _____

Dental History

Name of Family Dentist: _____ Date of last dental visit: _____

How many times a day do you **BRUSH**? 0 1 2 3+ How many times a day do you **FLOSS**? 0 1 2+

- Has this patient been examined by another orthodontist? No, If Yes, Date: _____, Name of orthodontist _____
- Has this patient ever had *orthodontic treatment* (braces)? No, If Yes, Date: _____, Name of dentist _____
- Has this patient been treated for TMJ problems? No, If Yes, Date: _____, Name of dentist _____
- Has this patient been treated for *gum disease*? No, If Yes, What kind of treatment? _____
- Has this patient had *root canal* treatment? No, If Yes, Which Teeth? _____
- Has this patient had *other* dental specialist treatment? No, If Yes, What? _____

- Does this patient have any of the oral habits? No, If Yes, Thumb sucking Finger sucking Lip Biting Tongue Thrusting Speech problems Mouth Breathing
Comments? _____

- Does this patient have any *TMJ (jaw joint) Symptoms*? No, If Yes, Grinding Clenching Jaw Joint Noises Headaches/Neckaches
Jaw Joint Pain Facial or Ear Pain Locking or difficulty moving of Jaws Dental/Facial Trauma Arthritis
Comments? _____

- Does this patient have any *Missing Permanent Teeth*? No, If Yes, Comment: _____
- Does this patient have any *Extra Permanent Teeth*? No, If Yes, Comment: _____
- Does this patient typically have *bleeding gums*? No, If Yes, Comment: _____
- Does this patient have *sores, lumps or irritated tissue* in the mouth? No, If Yes, Comment: _____
- Has this patient had any *injuries* to his/her teeth? No, If Yes, @ Age: _____ Chipped Broken Lost _____
- Has this patient had any *injuries* to his/her face or jaws or mouth? No, If Yes, @ Age: _____ Comment: _____
- Does this patient have or been informed of any *Speech Problems*? No, If Yes, Comment: _____
- Are there any other comments about this patient's dental history? No, If Yes, Comment: _____

Habit Alert? No

TMJ Alert? No

Patient and Family Concerns:

- Is this patient anxious about having orthodontic treatment? No, If Yes, Comment: _____

- What are this patient's concerns about orthodontic treatment? Appearance of Teeth Oral Function Crowding/Spacing Protrusion
 Other concerns or comments: _____

- Does the family dentist have any concerns about this treatment? No, If Yes, Comment: _____

- Do other family members have any concerns about this treatment? No, If Yes, Comment: _____

Family History of orthodontic treatment:

- *Mother*: No, If Yes: Dentist _____ Were you satisfied with the results? Yes, No _____
- *Father*: No, If Yes: Dentist _____ Were you satisfied with the results? Yes, No _____
- *Sister*: No, If Yes: Dentist _____ Were you satisfied with the results? Yes, No _____
- *Brother*: No, If Yes: Dentist _____ Were you satisfied with the results? Yes, No _____

Whom may we thank for referring you to our practice? _____

- ☺ If your dentist has taken new **full mouth** or **panoramic x-rays** in the past six months, *please bring them with you to the exam.*
- ☺ If you have had **orthodontic records** taken in the past six months, *please bring them with you to the exam.*
- ☺ If you are currently wearing an **orthodontic appliance** or **TMJ Splint**, *please bring it with you to the exam.*
- ☺ Is there any other medical or dental condition that we should know about? No, If Yes, Comment _____

I the undersigned have completed this medical and dental health history and certify that the preceding information is true and correct. This practice cannot be held responsible for any problems arising out of inadequate information not disclosed here. If there are any future changes in this information, I will inform this practice of these changes.

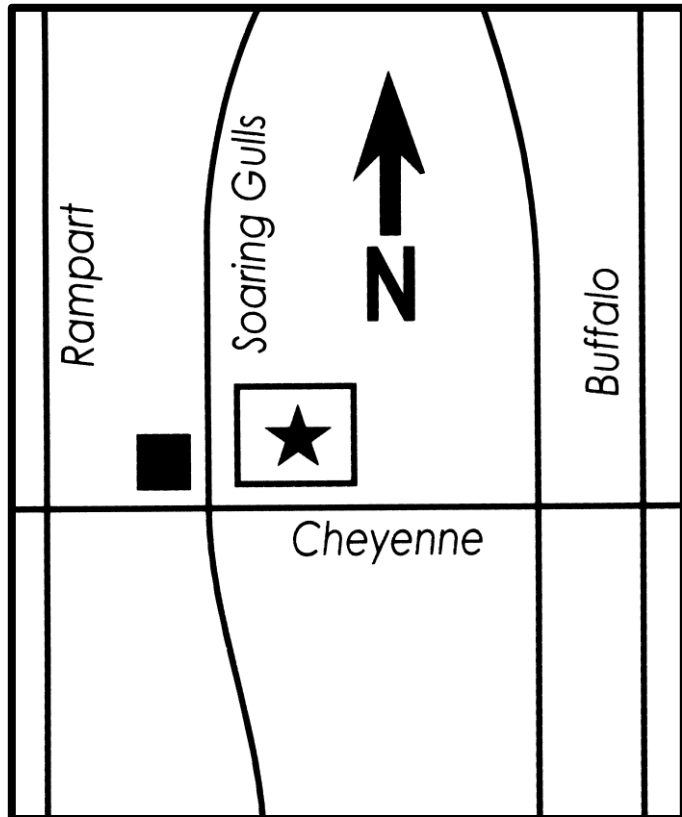
Signature of person filling out this history: _____ Date completed/signed: _____

Signature of TC who reviewed this history: _____ Date reviewed/signed: _____

Signature of DOCTOR who reviewed entire history: _____ Date reviewed/signed: _____

**Map
To
Our
Office:**

On Cheyenne Avenue.
Two stop lights West of Buffalo,
Across from Blockbuster



**Thank you for selecting our practice for your
SUPERSMILE ORTHODONTIC treatment.**

