FERNANDES ORTHODONTICS

NEW PATIENT QUESTIONNAIRE

Patient's Name _____ Date of Birth _____ Age _____

Parent's Name if patient is a minor _____

Residence Address _____ City _____ Zip _____

Home Phone _____ Business Phone _____

Email Address _____ Cell Phone _____

Occupation _____ Employer _____

Business Address _____ City _____ Zip _____

Marital Status _____ Spouse's Name _____

Spouse's Occupation _____ Employer _____

Who will be financially responsible? _____

Who may we thank for referring you to our office? _____

Purpose of this visit _____

PLEASE COMPLETE THE FOLLOWING IF YOU HAVE DENTAL INSURANCE

Name of person carrying Insurance _____ Date of Birth _____

Name of insurance company _____

Social security number of person carrying insurance _____

Policy number _____ Group number _____

Secondary Insurance _____

Name of person carrying insurace _____ Date of Birth _____

MEDICAL HISTORY

Name and phone number of physician _____

	YES	NO
Are you/patient now under medical treatment?		
Are you/patient now taking any medication?		
Have you/patient ever had an accident involving head or facial injury?		
Are you/patient allergic to any drugs?		
Are you/patient in good general health at this time?		

Have you/patient had any of the following?

Yes No		Yes No		Yes No		Yes No	
☐ ☐	Rheumatic Fever	☐ ☐	Hepatitis	☐ ☐	Neck Pains	☐ ☐	Arthritis (Any Type)
☐ ☐	Heart Murmur	☐ ☐	Diabetes	☐ ☐	Nerve or Brain Disease	☐ ☐	Sleep Apnea
☐ ☐	High Blood Pressure	☐ ☐	Ulcers	☐ ☐	Migraine	☐ ☐	Ear Disorder
☐ ☐	Heart Attack/Stroke	☐ ☐	Herpes (Any type)	☐ ☐	Epilepsy	☐ ☐	Sinus Infection
☐ ☐	Blood Vessel Disease	☐ ☐	Psoriasis	☐ ☐	Mental Health Problems	☐ ☐	Allergies
☐ ☐	Blood Disorder	☐ ☐	Cancer	☐ ☐	Bone Disorders	☐ ☐	Artificial Joint Replacement
☐ ☐	AIDS/HIV Infection	☐ ☐	Persistent Headaches	☐ ☐	Latex Allergy	☐ ☐	Fen-Phen History

Please list any significant medical history. _____

DENTAL HISTORY

Name and phone number of dentist _____

How long has it been since your/patient's last dental check up? _____

	YES	NO
Are you/patient currently having any dental problems?		
If so, what? _____		
Did your/patient's dentist inform you of any particular dental problems you may have?		
If so, what? _____		
Have you/patient ever had orthodontic treatment?		
Have you/patient ever had any problems or complication with dental treatment?		
Do you/patient ever clench or grind your teeth?		
Have you/patient ever had any gum problems or treatment?		
Are your/patient's teeth sensitive to hot, cold, or sweets?		
Are you/patient pleased with the way your teeth look?		

I give permission for the use of photographs and records made in the process of examination, treatment and retention to be used for the purposes of research, education, or publication in professional journals.

_____ _____ _____ _____

Doctors signature | Date | Signature of patient, or parent or guardian if patient is a minor | Date