FINDLAY ORTHODONTICS, INC.

1619 WEST MAIN CROSS
FINDLAY, OHIO 45840

Patient Questionnaire

Patient's Name: _____ Preferred name: _____
Last First MI

Date of Birth: _____ Sex: ☐ M ☐ F SSN# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Phone: _____

Name of School: _____ Grade: _____ Hobbies/Interests: _____

Family Status:

Spouse/Father's name: _____ ☐ Single ☐ Married ☐ Divorced
Last First MI

Address: _____ City: _____State: _____ Zip: _____

Home Telephone: _____Cell Phone: _____

Employer: _____ Work Telephone: _____

Spouse/Mother's name: _____ ☐ Single ☐ Married ☐ Divorced
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Phone: _____

Employer: _____ Work Telephone: _____

Do you have any other family members that have been or are now in orthodontic treatment? If yes, who _____

For your convenience, we offer appointment reminders via text or e-mail. If desired, please provide your cell phone number and/or email address: _____

Primary Dental Insurance:

Name of Subscriber: _____ Employer: _____

Date of Birth: _____ SSN# _____ Insurance ID # _____

Insurance Company: _____Group # _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance:

Name of Subscriber: _____ Employer: _____

Date of Birth: _____ SSN# _____ Insurance ID# _____

Insurance Company: _____ Group# _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

(Please complete back of form)

Dental History:

General Dentist: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of last dental examination: _____ Who referred you to our office? _____

Primary reason for seeking treatment: ☐ Esthetic ☐ Functional ☐ Health related

Has patient ever had previous orthodontic treatment? ☐ Yes ☐ No If so, date of treatment: _____/_____/_____

Name of previous orthodontist: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Has patient experienced any unfavorable reaction from any previous dental or medical care? ☐ Yes ☐ No

Is the patient aware of a problem: ☐ Yes ☐ No Patient's interest in treatment: ☐ Excited ☐ Willing ☐ Reluctant

Does/did the patient:

Grind his/her teeth at night? ☐ Yes ☐ No Have a habit of nail biting, thumb sucking or finger sucking? ☐ Yes ☐ No

Brush his/her teeth: ☐ Often ☐ Occasionally ☐ Reluctantly

Medical History:

Family physician: _____ Telephone: _____

Address: _____ City: _____State: _____ Zip: _____

Is patient currently under a physician's care? ☐ Yes ☐ No If yes, explain: _____

Is patient taking any medicine at this time? ☐ Yes ☐ No Please specify: _____

Is patient allergic to any medication? ☐ Yes ☐ No Please specify: _____

Does patient have any known allergies? ☐ Yes ☐ No Please specify: _____

Does patient require pre-medication (with antibiotics) for routine dental procedures? ☐ Yes ☐ No

If yes, please specify and give reason for this need: _____

If patient is currently experiencing or has a history of any disease, condition or problem not addressed, please explain:

_____

_____

_____

_____

_____

Signature: _____ **Date**: _____

Relationship to patient: _____