



This background questionnaire will help us get to know you better and allow us to better understand your needs. Please fill out this three page form and bring it with you to your first initial exam appointment.

This form is also available on-line at [www.DrBSmiles.com](http://www.DrBSmiles.com).

Thank You!

### ADULT PATIENT INFORMATION

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Date of Birth \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

(please fill out if you have dental insurance and you would like our insurance experts to estimate your benefits)

Insured's Name \_\_\_\_\_ Insured's Social Security/I.D. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Secondary - Insured's Name \_\_\_\_\_ Insured's Social Security/I.D. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

### MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**Please circle Yes or No (If Yes, please fill in details)**

Yes No Are you taking any medication? \_\_\_\_\_  
Yes No Ever treated for osteoporosis or treated with Bisphosphonates? \_\_\_\_\_  
Yes No Are you allergic to any medication? \_\_\_\_\_  
Yes No History of a major illness? \_\_\_\_\_  
Yes No Have you had any operations? \_\_\_\_\_  
Yes No Ever been involved in a serious accident? \_\_\_\_\_  
Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_  
Female Patients only:  
Yes No Is the patient pregnant? \_\_\_\_\_  
Yes No Are you anticipating becoming pregnant? \_\_\_\_\_  
Yes No Do you use any form of tobacco product? \_\_\_\_\_

Circle any of the medical conditions below that the patient has had or currently has.

|                              |                            |                          |                        |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes                   | Hepatitis/Liver problems | Pneumonia              |
| Anemia                       | Dizziness                  | Herpes                   | Prolonged Bleeding     |
| Arthritis                    | Epilepsy                   | High Blood Pressure      | Radiation/Chemotherapy |
| Asthma or Hayfever           | Gastrointestinal Disorders | HIV / Aids               | Rheumatic Fever        |
| Bone Disorders               | Heart Problems             | Kidney problems          | Tuberculosis           |
| Congenital Heart Defect      | Heart Murmur               | Nervous Disorders        | Tumor or Cancer        |

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

### ALLERGIES

Circle any known allergies the patient may have: Metal/Nickel Latex/Rubber Acrylic Other (specify) \_\_\_\_\_

### DENTAL HISTORY

General Dentist \_\_\_\_\_ Date of last visit? \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Yes No Are you presently in any dental pain? \_\_\_\_\_  
Yes No Ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_  
Yes No Do gums bleed when brushing? \_\_\_\_\_  
Yes No Any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Is the patient a mouth breather? \_\_\_\_\_  
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? \_\_\_\_\_  
Yes No Experience jaw clicking or popping? \_\_\_\_\_  
Yes No Aware of clenching or grinding teeth during the day? \_\_\_\_\_  
Yes No Experience "tension" headaches? \_\_\_\_\_  
Yes No Have you ever experienced chronic ringing in the ears? \_\_\_\_\_  
Yes No Do you need extra help with instructions? \_\_\_\_\_  
Yes No Do you need to take antibiotics prior to dental procedures? \_\_\_\_\_

Yes No To your best knowledge, has a panoramic x-ray be taken within the past 2 years? \_\_\_\_\_

**MOTIVATION**

1. What are you most interested in learning at our initial appointment? \_\_\_\_\_

2. Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_

3. Are you opposed to visible braces? \_\_\_\_\_

4. How long have you been thinking about visiting the orthodontist? \_\_\_\_\_

5. Are you sensitive or self-conscious about your teeth? \_\_\_\_\_

6. Please rank in numerical order 1 – 6 the relative importance of the following to you:

- |                                  |                                     |
|----------------------------------|-------------------------------------|
| _____ Preserving your teeth      | _____ Improved facial appearance    |
| _____ Improved dental appearance | _____ Improved comfort when chewing |
| _____ Improved dental function   | _____ Improved self-esteem          |

Other: \_\_\_\_\_

7. Please provide any additional information that will make us more helpful to you:

**Authorization**

I understand that the above information is needed to provide appropriate orthodontic treatment in a safe and efficient manner. All the questions above have been answered accurately to the best of my knowledge. Should any further information be needed, Bonavoglia Orthodontics, PLLC has my permission to ask the respective health care provider or agency. I will immediately inform Bonavoglia Orthodontics, PLLC of any changes in my health status or use of medications.

I authorize the use of my signature on all insurance submissions and I authorize Bonavoglia Orthodontics to release all information needed to secure the payments of benefits. **Also, notice of HIPPA Privacy Policy has been reviewed and explained to me.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_