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.

Thank You!

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date___________________

Patient's name ____
Last First Middle

Address____
Street City Zip

Nickname______________________ Date of Birth_______________ School___________________________

Number of Brothers and Sisters:____________________Other family members treated at our office:___________________________

Sports/Hobbies/Instruments Played ____

Whom may we thank for referring you to our office? ____

RESPONSIBLE PARTY INFORMATION

Name ____
Last First Middle

Residence____
Street City Zip

Mailing Address ____
Street City Zip

Home phone_____________________________Work phone _________________________________

Cell/other phone__________________________Email address _______________________________

Date of Birth______________________________Relationship to Patient _________________________

Employer_____________________________________ Occupation____________________ No. years employed ________________

Spouse's Name____ Relationship to Patient________________________

Employer_____________________________________ Occupation____________________ No. years employed ________________

Date of Birth ____________________________________Work Phone __________________

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 Is the patient taking any medication?____
Yes No Is the patient allergic to any medication? ____
Yes No History of a major illness? ____
Yes No Has the patient had any operations?____
Yes No Ever been involved in a serious accident? ____
Yes No Have seen a physician in the last 12 months? Why? ____
Yes No Does the patient use any form of tobacco product?____
Female Patients only:
Yes No Has menstruation started (used to determine skeletal maturity)? ______________________________________
Yes No Is the patient pregnant? ____

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 Is the patient presently in any dental pain?____
Yes No Ever experienced any unfavorable reaction to dentistry? ____
Yes No Has the patient 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 Has the patient ever experienced chronic ringing in the ears? ______________________________________
Yes No Does the patient need extra help with instructions? ____
Yes No Does the patient need to take antibiotics prior to dental procedures?_________________________________
Yes No Height of parents? Mom______ Dad______

Yes No To you 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. Has anyone in your immediate family received orthodontic treatment?____
How did they feel about the result?____

3. Has the patient ever seen an orthodontist? If yes, who and when?____

4. Is the patient opposed to visible braces?____

5. How long have you been thinking about visiting the orthodontist?____

6. Is the patient sensitive or self-conscious about his/her teeth?____

7. 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:____________________

8. 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: ____________________