

HAWKINS ORTHODONTICS

Patient Information Questionnaire

Welcome to our office! The following information is for our records only and will be considered confidential. Please fill out both sides of this form completely to help us give you the best care possible.

Date _____

Patient's Full Legal Name _____ Goes by _____

Address _____ City & Zip _____

How long at this address? _____ If applicable, with whom does the child live? _____

E-mail address _____ Home phone (_____) _____

Patient's age _____ Birthdate _____ \ \ _____ Gender: Male OR Female

Name/age siblings _____

Dentist's name _____ Phone number(_____) _____

Who is accompanying child today? _____ Relationship to child _____

Emergency Contact Person (not living with patient) _____ Phone number(_____) _____

FOR MINOR AND ADULT PATIENTS:

Patient / Father's / Husband's name _____ Employer _____

Business phone(_____) _____ Home(_____) _____ Cell(_____) _____

Home address (if different) _____ Custodial Parent: Y OR N

Occupation _____ How long? _____

Birthdate _____ \ \ _____ Social Security number _____

Patient / Mother's / Wife's name _____ Employer _____

Business phone(_____) _____ Home(_____) _____ Cell(_____) _____

Home address (if different) _____ Custodial Parent: Y OR N

Occupation _____ How long? _____

Birthdate _____ \ \ _____ Social Security number _____

FOR MINOR PATIENTS:

Marital status of parents: Married _____ Single _____ Divorced _____ Separated _____ Widowed _____

If Applicable, Stepfather's name _____ Stepmother's name _____

INSURANCE INFORMATION

Primary Dental Insurance _____ Secondary Dental Insurance _____

Insured's name _____ Relation _____ Insured's name _____ Relation _____

Birthdate _____ SS# _____ Birthdate _____ SS# _____

ID# _____ Group# _____ ID# _____ Group# _____

Employer _____ Employer _____

Insurance company phone# _____ Insurance company phone# _____

Insurance company claims address _____ Insurance company claims address _____

Do you have orthodontic coverage? Y N Don't know Do you have orthodontic coverage? Y N Don't know

Health History

Please circle YES or NO to the following questions:

1. Do you have difficulty chewing food or opening wide?.....YES NO
2. Do you have bleeding and/or inflammation of the gums?.....YES NO
3. Do you have problems breathing through your nose or have sinus problems?.....YES NO
4. Are you being treated by a physician for any condition at the present time?.....YES NO
5. Are you now taking, or have you previously taken any medication or drugs in the last six weeks?.....YES NO
a. If YES, please list _____
6. Have you ever had any injury to your head, face, or jaws?.....YES NO
7. Do your jaw joints pop or click?.....YES NO
8. Do you ever have pain in your jaw joints or muscles of the face or neck?.....YES NO
9. Please circle any of the following you have now or have had in the past:

Hepatitis	Heart Murmur	High Blood Pressure	Abnormal Bleeding	Rheumatic Fever
Epilepsy	Stroke	Tuberculosis	Jaundice	Artificial Bones/Joints/Valves
Kidney Disease	Stomach Ulcers	Venereal Disease	Infectious Mononucleosis	Asthma/Arthritis
Heart Attack	Liver Disease	HIV Positive	A.R.C	Congenital Heart Defect
Diabetes	Drug/Alcohol Abuse	Psychiatric Problems	Stomach Ulcers	Other

10. Do you experience headaches, eye trouble or ear trouble?.....YES NO
11. Do you have any disease, condition or problem not listed?.....YES NO
a. If YES, please explain: _____
12. FOR FEMALES ONLY: Are you pregnant?.....YES NO
a. If so, how many weeks? _____
13. Are you allergic to any of the following? Please circle: Penicillin Tetracycline Erythromycin Latex Sulfa Drugs Any Plastics/Metals
Please list any other drugs that you are allergic to: _____
14. What are the main concerns that you would like to address with orthodontics? _____
15. Have you ever had orthodontic treatment or been evaluated for orthodontic treatment?.....YES NO
16. Please explain any speech problems: _____
17. Are there any thumb sucking, finger sucking, lip biting, nail biting, pacifier habits?.....YES NO
18. Whom may we thank for referring you to our office? _____
19. Are there any other special concerns we should know about? _____

The above health information is true and correct. I will inform Dr. Michael Hawkins of any health status changes in the future.

Signature _____ Date _____
(Patient, Parent or Guardian)

Doctor's Notes

C.C. _____	Midlines _____
Dental Development: P EM MM LM ADOL ADULT	CR - CO Shift Ant___ L___ R___
Convex () Straight() Concave () Symmetry Y N Right () Left ()	Lack of keratinized tissue
Gingival Display Y N ___mm Hyperactive Mentalis Y N	ROM
Brushing: Good () Average () Below Average ()	TMJ EXAM
Class I () Class II div 1 () Class II div 2 () Subdiv R L Class III ()	Asymptomatic Y N
Max. Crowding ___mm Max. Spacing ___mm OJ ___mm	History of Trauma Y N
Mand. Crowding ___mm Mand. Spacing ___mm OB ___%	Facial Pain Y N Bi
Crossbite: Ant () Post () Quad () Bilateral ()	TMJ Clicking R L Bi
Habits: Thumb () Tongue () Lip () Bruxism ()	TMJ Crepitation R L Bi
Congenital Absence _____ Extractions _____	Lateral Pole Tenderness R L Bi
Impactions _____ Ankylosis _____ Fracture/Trauma _____	
Remarks: _____	