ADULT ORTHODONTIC DENTAL / MEDICAL QUESTIONAIRE

Dr. Barry Shapero
Email: newmarketorthodontics@rogers.com

Patient's Name:_____(Circle Sex): M / F
Date of Birth:_____Age:_____ Home Phone #: _____
Home Mailing Address:_____
PC_____Cell # _____ Work # _____
How did you hear about us?_____ Occupation _____
Will you be needing us to complete insurance forms? (Circle One) Yes / No

DENTAL HISTORY

Name and address of your dentist: _____
_____PC_____ Phone #_____
Name of any other dental care specialists you see:_____
Reason:_____
What are your orthodontic concerns?_____
Does anyone else in the family have similar condition?_____
Have they had treatment?_____Braces_____Appliances_____Extraction_____Surgery_____
Have you had any teeth removed?_____
Have you had any injuries to your head, face or teeth?_____
Do you clench or grind your teeth?_____
Did you ever suck a finger or thumb?_____To age_____Other habits?_____
Any difficulty chewing or swallowing food?_____
Do you have any pain or clicking when opening or closing in jaws?_____
Any speech problems?_____How often do you brush your teeth/day?_____
How would you classify your intake of sweets? High_____ Medium_____Low_____

MEDICAL HISTORY

Medical Doctor:_____ Present Health: Good_____ Fair_____ Poor _____
Date of last visit to doctor:_____Reason:_____
Any difficulties breathing, awake/asleep or through nose?_____
Asthma?_____Allergic to anything? metal, latex, drugs?_____
Heart Problems?_____Do you need premedication?_____
Circle: any history of rheumatic fever, convulsions, diabetes, repeated headaches,
sore throats/colds?_____
Any chronic conditions?_____ Do you bruise/bleed easily? Yes_____/ No_____
In hospital for any reason?_____
List any medications you take _____
Do you have hepatitus or HIV? _____ Have you had joint replacement? _____

Billing name for account:_____ Phone #_____
Billing Address:_____
PC_____ Today's Date:_____

Consent to release of information and to the dentist

I verify that the above information is true and I herby consent that Dr. Shapero may release any information to my insurance carrier and dentist of my choice.

Date _____ Signature _____

Person responsible for the account

Name _____ Address _____
Phone _____
_____