ORTHODONTIC DENTAL / MEDICAL QUESTIONAIRE

Dr. Barry Shapero
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Patient's Name:_____ Age: _____ (Circle Sex): M / F
Date of Birth: _____ Home #_____Today's Date_____
Home Mailing Address_____PC _____
Billing Person/s & Address_____PC _____
Father/Guardian/Step-Father (Circle One) Name:_____
Work Phone #_____ Cell # _____
If Other Home Address:_____PC _____
Mother/Guardian/Step-Mother (Circle One) Name:_____
Work Phone #_____ Cell # _____
If Other Home Address:_____PC_____
Patient Lives With:_____ Patient's School:_____ Grade: _____
Number of Siblings: _____ Ages: ( ) ( ) ( ) ( ) ( )
What are the orthodontic concerns? _____
How did you hear about us? _____ Do you need insurance forms?_____

DENTAL HISTORY

Name and address of patient's dentist: _____
_____PC_____ Phone # _____
Age first seen by dentist: _____Age 1st baby tooth came in?_____
Have any teeth been removed by dentist?_____ How often does patient brush/day_____
Does patient grind or clench teeth? _____ Any injuries to teeth, face or head? _____
Any finger/thumb sucking? _____ Has patient seen an orthodontist before? _____
Any problems chewing/swallowing/opening/closing? _____
Any other family members had orthodontic treatment? _____
If so, please circle: Braces / Appliances / Extractions / Surgery
Patient's intake of sweets: High / Medium / Low (Circle One)

MEDICAL HISTORY

Name of medical doctor:_____ Present Health: _____
Date of last doctor's visit: _____ Reason: _____
Any problems breathing, (awake or asleep) through nose? _____
Have tonsils/adenoids been removed?_____Asthma? _____
Any speech problems?_____ Speech Therapy? _____
Does patient bleed or bruise easily? _____ Present Medications:_____
Any allergies to metal / latex / drugs / environmental ? _____
In hospital for any reason? _____ Heart problems? _____
Does patient need to be premedicated for dental work?_____
Any special concerns or needs we should know about?_____
Any family history of rheumatic fever, convulsions, diabetes, repeated headaches or repeated sore throats or colds?_____
Does patient have hepatitis or HIV? _____Any joint replacements?_____

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 _____