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!

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 have x-rays been taken within the past 2 years?_____

AIRWAY ASSESSMENT

Yes No Has your doctor ever recommended that you see an ENT?
Why?_____Date of appointment:_____
Yes No Has your doctor ever recommended that you have your adenoids/tonsils removed?
Why?_____ Date of surgery:_____
Yes No Do you have seasonal allergies?_____
Yes No Do you snore at night? How frequently?_____
Yes No Do you have a disruptive sleep pattern and/or daytime fatigue?_____
Yes No Do you sleep with your mouth open?_____
Yes No Are you a day-time mouth breather?_____
Yes No Is there any family history of sleep apnea? Who?___ _____

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 <u>to you</u>:

_____ 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 HIPAA Privacy Policy has been reviewed and explained to me.**

Signature: _____Date: _____