WEST HOUSTON ORTHODONTICS

GET ACQUAINTED QUESTIONNAIRE ADULT

Vladimir Tabakman, D.D.S., M.S. & Associates

Specialist in Orthodontics for Children and Adults

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's full name_____ Date of Birth_____ Age___ Phone_____
Address_____ City_____ State_____ Zip_____
Email Address(es)_____
Family Dentist_____ City_____ Phone_____ Last Visit_____
Family Physician_____ City_____ Phone_____
Name patient likes to be called_____ Musical instrument played_____
Sports, Hobbies, etc._____
Married_____ Separated_____ Divorced_____ Widowed_____
Children (names/ages)_____
Major reason for seeking orthodontic treatment_____
Whom may we thank for referring you?_____

DENTAL HISTORY

	No	Unsure	Yes	
Have there been any injuries to the face, mouth or teeth?	□	□	□	notes:_____
Are you aware of any missing or extra permanent teeth?	□	□	□	notes:_____
Do you have any speech problems or concerns?	□	□	□	notes:_____
Are you especially apprehensive toward dental visits?	□	□	□	notes:_____

Do you:

• Clench or grind your teeth?	□	□	□	notes:_____
• Brush your teeth conscientiously?	□	□	□	notes:_____

Do you have:

• A history of periodontal (gum) problems?	□	□	□	notes:_____
• A problem with frequent cold/canker sores?	□	□	□	notes:_____
• Any difficulty opening your mouth?	□	□	□	notes:_____
• Any clicking or discomfort in jaw joints near ears?	□	□	□	frequency:_____
• Headaches or neckaches regularly?	□	□	□	frequency:_____
• Pain in the jaw joints while eating?	□	□	□	frequency:_____
• Any congenital abnormalities? (Cleft palate,etc.)	□	□	□	describe:_____

ATTITUDE TOWARD TREATMENT

Are you aware of spaced, crooked or protruding teeth? □ No □ Yes Concerned? □ No □ Yes
Do you feel that it is becoming: □ Better □ Worse □ Staying the Same
What would you most like to have orthodontic treatment accomplish?_____
Would you object to wearing orthodontic appliances (braces) should they be indicated? □ No □ Yes
Are you aware that some appointments will infringe upon school/work time? □ No □ Yes
Have you had any previous orthodontic examinations? □ No □ Yes Doctor:_____ Date:_____
Have you had any previous orthodontic treatment? □ No □ Yes Describe:_____

PLEASE COMPLETE REVERSE SIDE →

MEDICAL HISTORY

Please check no or yes to the following and indicate the year

	No	Yes	Years		No	Yes	Years
Attention Deficit Disorder	___	___	___	Hay Fever	___	___	___
Allergies	___	___	___	Healing Disorder	___	___	___
Anemia or Bleeding Problems	___	___	___	Headaches	___	___	___
Arthritis	___	___	___	Hearing Disorder	___	___	___
Asthma	___	___	___	Heart Disorders	___	___	___
Behavioral Problems	___	___	___	Hepatitis or Liver Disorders	___	___	___
Bone or Joint Disorder	___	___	___	HIV Positive	___	___	___
Breathing or Nasal Disorder	___	___	___	Kidney or Bladder Condition	___	___	___
Diabetes	___	___	___	Mononucleosis	___	___	___
Earaches	___	___	___	Nervous Disorders	___	___	___
Epilepsy or Convulsions	___	___	___	Psychiatric Treatment	___	___	___
Fainting or Dizziness	___	___	___	Psychological Disorder	___	___	___
Gagging or Nausea Problems	___	___	___	Rheumatic Fever	___	___	___
Growth or Endocrine Condition	___	___	___	Venereal Disease	___	___	___

General health: □ Good □ Fair □ Poor □ Birth Defects_____

Presently under medical care for _____

Drugs or medication being taken now (drug & dose) _____

Allergic to any medication _____

Do you require antibiotic premedication prior to dental appointments? □ No □ Yes

Are you a mouth breather? □ No □ Yes □ While asleep □ While awake

Have tonsils and adenoids been removed? □ No □ Yes At what age?_____

Do you snore at night? □ No □ Yes

RESPONSIBLE PARTY INFORMATION

Name_____

Residence_____

Mailing Address_____

How long at this address_____Home Phone_____Work Phone_____

Social Security #_____Birthdate_____ Relationship to Patient_____

Employer_____Occupation_____No. Years Employed_____

Spouse's Name_____

Employer_____Occupation_____No. Years Employed_____

Social Security #_____Birthdate_____Work Phone_____

Emergency contact person_____

Name Home Phone Work Phone

ORTHODONTIC INSURANCE INFORMATION

Insurance Company_____Group No._____Local No._____

Insurance Co. Address_____

Insured's Name_____Insured's Soc. Sec. #_____

Insured's Employer_____

Do you have dual coverage? □ No □ Yes If Yes:_____

Insurance Company_____Group No._____Local No._____

Insurance Co. Address_____

Insured's Name_____Insured's Soc. Sec. #_____

Insured's Employer_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature_____Date_____

I give permission for x-rays and photographs to be used for research/educational purposes_____

Initials