ADULT

Ronconi Orthodontics

SS____

We are pleased that you called our office for your Orthodontic Evaluation. At this appointment a preliminary evaluation and diagnosis will be made. The visit will take approximately one hour. If orthodontic treatment is indicated, arrangements will be made to take diagnostic records. To make the most efficient use of your time, we request that you please complete the following questionnaire and bring with you to your appointment.

Patient's Full Name ______________________ Sex: M / F Age ______ Birthdate __________________
Address __________________________ City ______________ State ______ Zip ____________
Hm Ph ___________ Cell Ph __________ Rent/Own SS # ____________ Marital Status: S/M/D/W
E-Mail Address ____________________

Employer ____________________ Occupation ________________ How Long? ___________
Address _______________________ Wk Phone ______________________________

Spouse ______________________ SS # ________________ Birthdate ______________
Employer ____________________ Occupation ________________ How Long? ___________
Address _______________________ Wk Phone ______________________________

Any immediate family members treated here? ☐ **Yes** ☐ **No** If yes, their names are____________________

What is the primary reason for your visit today? ____

Primary Orthodontic Insurance ____________________ Group # ___________ Plan # _______
Insured Employee ____________________ Birthdate ___________ SS # _______________
Secondary Orthodontic Insurance ____________________Group # ___________ Plan # _______
Insured Employee ____________________ Birthdate ___________ SS # _______________
Person Responsible for account ____________________ Relationship _______________
I authorize a review of my credit necessary to qualify for office payment plans : ☐ **Yes** ☐ **No**

DENTAL HISTORY: Patient's Dentist ______________________ City __________________

Has the patient ever had any injuries to the face/mouth/teeth? ☐ **Yes** ☐ **No**
Is the patient a mouth breather? ☐ **Yes** ☐ **No**
Have you ever had any jaw clicking or popping? ☐ **Yes** ☐ **No**
If yes, ☐ Awake ☐ Asleep
Are there any missing or extra permanent teeth? ☐ **Yes** ☐ **No**
Is excessive snoring a problem? ☐ **Yes** ☐ **No**
Has an orthodontist been consulted previously? ☐ **Yes** ☐ **No**
Is sleep Apnea a problem? ☐ **Yes** ☐ **No**
Do you smoke? ☐ **Yes** ☐ **No**

MEDICAL HISTORY: Patient's Physician ____________________ City __________________

Is patient in good health? ☐ **Yes** ☐ **No**
Does patient have any history of major illness? ☐ **Yes** ☐ **No**
Have tonsils or adenoids been removed? ☐ **Yes** ☐ **No**

Does patient have tendency to : ☐ **Colds** ☐ **Ear Infections** ☐ **Sore Throats**

List any medications now being taken. Give reasons. ______________________________
List any allergies or medication sensitivities: ______________________________

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

Condition			Condition			Condition		
Diabetes	☐ **Y**	☐ **N**	Anemia	☐ **Y**	☐ **N**	Prolonged Bleeding	☐ **Y**	☐ **N**
Auto Immune Diseases	☐ **Y**	☐ **N**	Epilepsy	☐ **Y**	☐ **N**	Fainting or Dizziness	☐ **Y**	☐ **N**
Heart Trouble	☐ **Y**	☐ **N**	Asthma	☐ **Y**	☐ **N**	Nervous Disorders	☐ **Y**	☐ **N**
Rheumatic Fever	☐ **Y**	☐ **N**	Kidney Involvement	☐ **Y**	☐ **N**	Liver Involvement	☐ **Y**	☐ **N**
Osteoporosis	☐ **Y**	☐ **N**	Hepatitis	☐ **Y**	☐ **N**	Arthritis	☐ **Y**	☐ **N**
Tuberculosis	☐ **Y**	☐ **N**	Endocrine Problems	☐ **Y**	☐ **N**	LATEX Allergy	☐ **Y**	☐ **N**