



PATIENT HEALTH QUESTIONNAIRE FOR: _____

Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

Have you been evaluated by another orthodontist? _____

Emergency Contact (Full Name & Phone Number) _____

Address _____

Phone _____

Email _____

Insured's Name _____

Insured's Date of Birth _____

Insured's S.S.# _____

Insured's Employer _____

Dental Insurance Co. _____

- | | |
|--|--|
| <input type="checkbox"/> Crowded teeth | <input type="checkbox"/> Over bite |
| <input type="checkbox"/> "Buck teeth" | <input type="checkbox"/> Receded jaw |
| <input type="checkbox"/> Prominent jaw | <input type="checkbox"/> Gummy smile |
| <input type="checkbox"/> Spacing between teeth | <input type="checkbox"/> Gum disease / recession |
| <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Jaw dysfunction |
| <input type="checkbox"/> Mouth too small | <input type="checkbox"/> Clicking jaw joint |
| <input type="checkbox"/> Irregular teeth | <input type="checkbox"/> Protrusion of teeth |
| <input type="checkbox"/> Ears ring / stuffy | <input type="checkbox"/> Headache / face pain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Irregular facial appearance | <input type="checkbox"/> Other _____ |

FAMILY MEMBERS WITH SIMILAR CONDITION(S)

- Father Mother Brother Sister
 Other _____

PATIENT'S CURRENT PHYSICAL HEALTH

- Excellent Good Fair Poor

KNOWN OR SUSPECTED ALLERGIES

- Antibiotics _____
 Pain pills _____
 Foods _____
 Environmental allergies _____
 None

_____ **PLEASE INITIAL**

CONDITIONS THE PATIENT HAS OR HAS HAD

- AIDS
 Allergies
 Asthma
 Autoimmune disorders
 Blood disease
 High blood pressure
 Low blood pressure
 Bone disorders
 Cancer
 Diabetes
 Dizziness
 Eating disorders
 Endocrine problems
 Emotional problems
 Female problems
 HIV positive status
 Hepatitis
 Heart disease
 Heart murmur
 Hearing disorder
 Kidney disease
 Rheumatic fever
 Ringing of the ears
 Sleep disturbance
 History of trauma:
 Teeth Face Jaws Head
 None of the above

_____ **PLEASE INITIAL**

CURRENT MEDICATIONS

- Heart pills
 Antibiotics _____
 Diet pills _____
 Pain pills _____
 Vitamins
 Birth control pills
 Muscle relaxants
 Insulin
 Other _____
 None

_____ **PLEASE INITIAL**

PRIMARY BREATHING PATTERN

Mouth Nose
 Depends on _____

DOES THE PATIENT SNORE WHEN SLEEPING?

Yes No
 Sometimes _____

DIFFICULTY CHEWING?

No
If yes, please indicate below which apply:
 Teeth don't meet well
 Pain when chewing
 Other _____

CHECK ALL THAT APPLY

Frequent sore throat / tonsillitis
 Speech problems
 Pain in the RIGHT jaw joint
 Pain in the LEFT jaw joint
 Clicking / popping in the RIGHT jaw joint
 Clicking / popping in the LEFT jaw joint
 Previous thumb / finger sucking habit
 Lip biting / sucking habit
 Grind teeth
 Clench jaws
 Tongue thrust when swallowing

HAS (CHILD) PATIENT REACHED PUBERTY

Yes, approximate date _____
 No

FREQUENCY OF DENTAL CHECKUPS

Once per year
 Twice per year
 More than twice a year
 Emergencies only
 Never

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

Wants treatment
 Only if necessary
 Unwilling
 Will cooperate if treatment is needed
 Uncooperative

ORTHODONTIC EXAM PROMPTED BY

Patient Mother Spouse
 Dentist Father Sibling
 Doctor Friend Other

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?

If yes, please describe:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers.
- Conduct normal health & dental care operations such as quality assessments and physicians certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices*. From time to time and that I may contact Dental Health Associates at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. In addition, I understand you are not required to agree to my requested restrictions.

PATIENT NAME (PRINT) _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

DATE _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THE *NOTICE OF PRIVACY PRACTICES*, BUT WAS UNABLE TO DO SO AS DESCRIBED BELOW:

DATE _____ INITIAL _____

REASON _____