Ronconi Orthodontics

ADULT

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 01/28/2021
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

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