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Specializing in Orthodontics for Children and Adults

A B C

**Patient Information**

Date \_\_\_\_\_ Age \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Dentist \_\_\_\_\_

Parent Email \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

With whom does the patient reside? \_\_\_\_\_

Whom may we thank for recommending our services? \_\_\_\_\_

Names and ages of children in family	Have any been seen in this office?	Yes	No
_____	_____	_____	_____
_____	_____	_____	_____

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number of years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number of years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes, please provide us with insurance card

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_

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

Signature (Parent's signature if minor) \_\_\_\_\_

CONFIDENTIAL (for record and pre-treatment evaluation)

# Please Answer All Questions

## A. What are the patient's or parent's main concerns regarding the jaws and teeth?

- Crowding
- Over-bite
- "Buck" teeth
- Receded jaw
- Prominent jaw
- Gummy smile
- Spaces
- Gum disease/recession
- Missing teeth
- Jaw dysfunction
- Mouth too small
- Clicking jaw joint
- Irregularly shaped teeth
- Protrusion of teeth
- Ringing/Stiffness of ears
- Headache/Facial pain
- Neck pain
- Jaw pain
- Irregular facial proportions
- Other \_\_\_\_\_
- No Concerns

## B. Other family members with similar orthodontic condition?

- Father
- Mother
- Brother
- Sister
- Other
- None

## C. Medical / Dental History

1. Present Health
 

Good	Fair	Poor
1 2 3 4 5		

  - a. Physical
  - b. Emotional
2. If a child, has patient reached puberty?
 

Yes	No
1 2 3 4 5	
3. Has the patient ever had any of the following conditions?
  - Allergies
  - Arteriosclerosis
  - Asthma
  - Autoimmune disorder
  - Blood disease
  - High blood pressure
  - Low blood pressure
  - Bone disorders
  - Cancer
  - Diabetes
  - Dizziness
  - Epilepsy
  - Endocrine problems
  - Emotional problems
  - Female problems
  - Hepatitis
  - Heart disease
  - Hearing disorder
  - Kidney disease
  - Rheumatic fever
  - Ringing of ears
  - Sleep disturbances
  - Received trauma (teeth, face, jaws or head)
  - Other \_\_\_\_\_
  - None

## D. MEDICATIONS: Current medication taken by the patient

- Heart pills (digitalis, etc.)
- Antibiotics
- Diet pills (diuretics)
- Pain pills (demerol, codeine, etc.)
- Vitamins
- Birth control pills
- Sleeping pills
- Muscle relaxants
- Insulin
- Other \_\_\_\_\_
- None

## E. ALLERGIES TO MEDICATION/FOOD

The patient demonstrates an allergic response to:

- Antibiotics (specific)
- Pain pills (codeine, etc.)
- Dairy products
- Wheat, cereals
- Dyes in food
- Other \_\_\_\_\_
- None

## F. The following are also of interest to the orthodontist.

Does the patient:

1. Snore when sleeping?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
2. Breathe through the mouth? (mouth breather rather than nose breather)
  - Seldom
  - Sometimes
  - Usually
3. Have difficulty chewing?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
4. Have pain in the jaw joint?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
5. Have clicking in jaw joint?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
6. Have speech problems?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

## G. The following habits are of interest to the orthodontist:

1. Thumb or finger sucking
  - Never
  - Previous
  - Presently
2. Lip biting or sucking?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
3. Grinding of teeth?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
4. Tongue thrusting?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
5. Smoking?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
6. Other habits?
 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

## H. DENTAL/ORTHODONTIC AWARENESS

### 1. How often does the patient have Dental Check-ups?

- Twice a year
- Once a year
- Only if urgent
- Never

### 2. Is patient aware of any orthodontic problems?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

### 3. Patient's interest in orthodontic treatment:

- Wants treatment
- Treatment if necessary
- Unwilling but agrees
- Minimal

### 4. Orthodontic consultation prompted by

- Patient
- Dentist
- Mother
- Father
- Spouse
- Sibling
- Physician
- Friend
- Other

### 5. Has the patient had previous orthodontic consultation or treatment?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

### 6. Has the patient had any unusual dental experiences?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

### 7. Are there any medical, dental, or surgical problems not covered above?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

## I. Why did the patient seek this consultation?

- To correct over-bite
- To eliminate crowding
- To correct jaw dysfunction problem
- To eliminate facial pain
- To close spaces
- To improve facial proportions
- To improve general appearance
- Other \_\_\_\_\_

## J. Toothbrushing

- Regular
- Irregular
- Occasional

## K. Scholastic ability

- Outstanding
- Above average
- Excellent
- Average

## L. Personal Neatness

- Very concerned
- Average
- Not a priority

## M. Room Tidiness

- Outstanding
- Average
- Not a priority