

# BAUM ORTHODONTIC ASSOCIATES

## NEW PATIENT QUESTIONNAIRE

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Parent's Name if patient is a minor \_\_\_\_\_  
Residence Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Occupation/School \_\_\_\_\_ Employer \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Spouse's Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Who will be financially responsible? \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_  
Purpose of this visit \_\_\_\_\_

### PLEASE COMPLETE THE FOLLOWING IF YOU HAVE DENTAL AND/OR MEDICAL INSURANCE

Name of person carrying insurance \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of insurance company, Dental \_\_\_\_\_ Medical \_\_\_\_\_  
Social security number of person carrying insurance \_\_\_\_\_  
Policy or group number, Dental \_\_\_\_\_ Medical \_\_\_\_\_  
Secondary Insurance, name & phone number \_\_\_\_\_

### MEDICAL HISTORY

Name and phone number of physician \_\_\_\_\_

	YES	NO
Are you/patient now under medical treatment? .....	_____	_____
Are you/patient now taking any medication? .....	_____	_____
Have you/patient ever had an accident involving head or facial injury? .....	_____	_____
Are you/patient allergic to any drugs? .....	_____	_____
Are you/patient in good general health at this time? .....	_____	_____

Have you/patient had any of the following?

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Neck Pains	<input type="checkbox"/> <input type="checkbox"/> Arthritis (Any Type)
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Nerve or Brain Disease	<input type="checkbox"/> <input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Migraine	<input type="checkbox"/> <input type="checkbox"/> Ear Disorder
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> <input type="checkbox"/> Herpes (Any type)	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Sinus Infection
<input type="checkbox"/> <input type="checkbox"/> Blood Vessel Disease	<input type="checkbox"/> <input type="checkbox"/> Psoriasis	<input type="checkbox"/> <input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> <input type="checkbox"/> Swollen Glands
<input type="checkbox"/> <input type="checkbox"/> Blood Disorder	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Bone Disorders	<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Infection	<input type="checkbox"/> <input type="checkbox"/> Persistent Headaches		

Please list any significant medical history.

\_\_\_\_\_

### DENTAL HISTORY

Name and phone number of dentist \_\_\_\_\_

How long has it been since your/patient's last dental check up? \_\_\_\_\_

	YES	NO
Are you/patient currently having any dental problems? .....	_____	_____
If so, what? _____		
Did your/patient's dentist inform you of any particular dental problems you may have? .....	_____	_____
If so, what? _____		
Have you/patient ever had orthodontic treatment? .....	_____	_____
Have you/patient ever had any problems or complication with dental treatment? .....	_____	_____
Do you/patient ever clench or grind your teeth? .....	_____	_____
Have you/patient ever had any gum problems or treatment? .....	_____	_____
Are your/patient's teeth sensitive to hot, cold, or sweets? .....	_____	_____
Are you/patient pleased with the way your teeth look? .....	_____	_____

\_\_\_\_\_  
Signature of patient, or parent or guardian if patient is a minor

\_\_\_\_\_  
Date