Adult Personal & Health Questionnaire

All questions in this questionnaire are strictly confidential and become a part of your medical history.

Full Name:_____ Sex: M or F D.O.B. _____ Age ____ SS#_____-_____-_____
Home Address: (Street/City/State/Zip) _____
Home Phone: _____ Work:_____ Mobile:_____ Email:_____
Marital Status: ____ *(S/M/D/W)* Spouse Name:_____
Occupation:_____ Employer:_____
How did you hear about our office? _____

Medical History

Have you ever been treated for the below: *(Check those that apply)*

Yes/No	*Yes/ No*	*Yes/ No*	*Yes/ No*	*Yes/ No*
☐☐ Endocrine Problems	☐☐ Prolonged Bleeding	☐☐ Hepatitis	☐☐ Diabetes	☐☐ Arthritis
☐☐ Nervous Disorder	☐☐ Heart Problems	☐☐ Cancer	☐☐ Liver Problems	☐☐ Asthma
☐☐ Rheumatic Fever	☐☐ Bone Disorder	☐☐ Fainting	☐☐ Birth Defects	☐☐ AIDS/HIV

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? ____ If so, which drug? _____
Do you have any disease, condition, or problem not listed that you think we should know about?
Please explain: _____
Are you under the care of a physician? If yes why? _____
Are you taking any medication at this time? ☐Yes ☐ No If, yes, please list: _____
Do you have any allergies? ☐Yes ☐ No If, yes, please list:_____

Dental History

Yes/ No

☐☐ Have there been any injuries to the face, mouth or teeth?
☐☐ Do you have any problems with speech?
☐☐ Have you been informed of any missing permanent teeth?
☐☐ Do you play a wind instrument? What Kind? _____
☐☐ Have you had any previous orthodontic exam or treatment?
☐☐ Any cavities not filled? _____
☐☐ Any gum problems? _____
Your Dentist Name _____
Last Cleaning Date_____
How often do you brush? _____

TMJ History

Yes/No

☐☐ Do you grind your teeth?
☐☐ Do you have or have had any discomfort or clicking in jaw joints?
☐☐ Do you have pain or ringing in the ear?
☐☐ Are any teeth sore or sensitive?
☐☐ Has the jaw ever locked or slipped out of place?
☐☐ Do you have frequent headaches?

Billing Party Information (if different from above)

Name:_____ Relationship to Patient:_____ Sex: M or F D.O.B.:_____
Home Address: *(Street/City/State/Zip)*
_____
Home Phone:_____ Work Phone:_____ Mobile:_____
SSN:_____-_____-_____ Email:_____
Marital Status:_____Spouse:_____
Employer: _____ Occupation: _____No. of yrs Employed:_____

Dental Insurance Information

Policy Holders Name:_____ SSN: ___-___-_____ Birth Date:_____
Insurance Company: _____Policy ID#:_____ Group#:_____
Insurance Company Address:_____ Phone:_____
Employer:_____ Employer Address:_____
Relationship to patient:_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes to child's medical status. If this office accepts insurance, I understand that I am responsible for payment of any co-payment or deductibles or any fee that my insurance does not cover.

Signature of Patient_____ **Date**_____ (A_NPQ)

Child Personal & Health Questionnaire

All questions in this questionnaire are strictly confidential and become a part of your medical history

Full Name: _____ *(Nick Name)* _____ Sex: M or F D.O.B.: _____ Age: ____
Home Address: (Street/City/State/Zip) _____
Home Phone: _____ Mobile Phone: _____ Email: _____
Mother's Name : _____ Father's Name: _____
How did you hear about our office? _____

In the event your child misses school, we send Doctor's Excuses/School Notes.
My child goes to: _____

Medical History

Have you ever been treated for the below: *(Check those that apply)*

Yes/No	*Yes/ No*	*Yes/ No*	*Yes/ No*	*Yes/ No*
☐ ☐ Endocrine Problems	☐ ☐ Prolonged Bleeding	☐ ☐ Hepatitis	☐ ☐ Diabetes	☐ ☐ Arthritis
☐ ☐ Nervous Disorder	☐ ☐ Heart Problems	☐ ☐ Cancer	☐ ☐ Liver Problems	☐ ☐ Asthma
☐ ☐ Rheumatic Fever	☐ ☐ Bone Disorder	☐ ☐ Fainting	☐ ☐ Birth Defects	☐ ☐ AIDS/HIV

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? ____ If so, which drug? _____
Do you have any disease, condition, or problem not listed that you think we should know about?
Please explain: _____
Are you under the care of a physician? If yes why? _____
Are you taking any medication at this time? ☐ Yes ☐ No If, yes, please list. _____
Do you have any allergies? ☐ Yes ☐ No _____

Dental History

Yes/ No

☐ ☐ Have there been any injuries to the face, mouth or teeth?
☐ ☐ Do you have any problems with speech?
☐ ☐ Have you been informed of any missing permanent teeth?
☐ ☐ Do you play a wind instrument? What Kind? _____
☐ ☐ Have you had any previous orthodontic exam or treatment?
☐ ☐ Any cavities not filled? _____
☐ ☐ Any gum problems? _____

Your Dentist Name _____
Last Cleaning Date _____
How often do you brush? _____
How often do you floss? _____

TMJ History

Yes/No

☐ ☐ Do you grind your teeth?
☐ ☐ Have you experienced any discomfort or clicking of the jaw joints?
☐ ☐ Do you have pain or ringing in the ears?
☐ ☐ Are any teeth sore or sensitive?
☐ ☐ Has the jaw ever locked or slipped out of place?
☐ ☐ Do you have frequent headaches or neck aches?

Billing Party Information

Name: _____ Relationship to Patient: _____ Sex: M or F D.O.B.: _____
HomeAddress: *(Street/City/State/Zip)* _____
Home Phone: _____ Work Phone: _____ Mobile: _____
SSN: ____-____-____ Email: _____
Marital Status: _____ Spouse: _____
Employer: _____ Occupation: _____ No. of yrs employed: _____

Dental Insurance Information

Policy Holders Name: _____ SSN: ___-___-____ D.O.B.: _____
Insurance Company: _____ Policy ID: _____ Group No.: _____
Insurance Company Address: _____ Phone: _____
Employer: _____ Employer Address: _____
Relationship to patient: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform the office of any changes to my child's medical status. If this office accepts insurance, I understand that I am responsible for payment of any co-payment, deductibles or any fee that my insurance does not cover.

Signature of Parent: _____ **Date:** _____ (C_NPQ)

HIPAA Acknowledgment

SING
ORTHODONTICS

1500 S. AW Grimes Blvd. #190
Round Rock, TX 78664

3313 RR 620 S. #300
Lakeway, TX 78738

ACKNOWLEDGEMENT FORM

I have reviewed the HIPAA agreement.

Patient Name: (PRINT) _____

Patient / Guardian Signature: _____

Date: __ / __ / ____