Manfred Quentel, D.D.S. -- James S. Henson D.D.S.

ORTHODONTICS

www.quentelhenson.orthodontics.com

_____
Date

1 PATIENT INFORMATION

Name:_____ _____ Phone (____)_____
First Mi Last Called Name

Address:_____ Birthday_____

City:_____ State:_____ Zip: _____ Age:_____ Sex:_____

2 ADULT INFORMATION

EMAIL_____

FATHER or SELF or GUARDIAN INFORMATION

Name:_____
First Mi Last

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____

Birthday:_____Age:_____Sex:_____Marital Status:_____

Driver's License #:_____S.S. #:_____

How Long at This Address_____ How Long at Previous Address_____

Previous Address if Less Than 3 Years:_____

EMPLOYER/INSURANCE INFORMATION

Employer Name:_____

Employer Address:_____

Employer City:_____State:_____Zip:_____

Number of Years Employed_____Occupation_____

Orthodontic Coverage ? Yes___ No___

Insurance Company Name:_____

Insurance Address:_____

Insurance City:_____State:_____Zip:_____

Insurance Phone:_____ext:_____

Group #:_____ Local or Union #:_____

MOTHER or SPOUSE INFORMATION

Name:_____
First Mi Last

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____

Birthday:_____Age:_____Sex:_____Marital Status:_____

Driver's License #:_____S.S. #:_____

How Long at This Address_____ How Long at Previous Address_____

Previous Address if Less Than 3 Years:_____

EMPLOYER/INSURANCE INFORMATION

Employer Name:_____

Employer Address:_____

Employer City:_____State:_____Zip:_____

Number of Year Employed_____Occupation_____

Orthodontic Coverage ? Yes___ No___

Insurance Company Name:_____

Insurance Address:_____

Insurance City:_____State:_____Zip:_____

Insurance Phone:_____ext:_____

Group #:_____Local or Union #:_____

3 OTHER INFORMATION

Who is the Responsible Party:_____ Who may we thank for referring you?_____

Dentist Name:_____ Sports or Hobbies:_____

Address:_____Phone #:_____ School Name:_____ Grade:_____

Physician Name:_____ Number of Brothers:_____ Ages:_____

Address:_____Phone #:_____ Number of Sisters:_____ Ages:_____

4 MEDICAL INFORMATION

	YES	NO
Frequent or Severe Headaches:		
Any Heart Disease:		
Any Sinus or Respiratory Disease:		
Any Blood Disease:		
Any Liver Disease:		
Any Thyroid Disease:		
Any Kidney Disease:		
H.I.V. Positive:		
Any Venereal Disease:		
Any Intestinal Disease:		
Any Bone Disease:		
Any Nervous /Emotional Problems:		
Any High or Low Blood Pressure:		
Any Endocrine Problems:		
Any Problems with Wounds Healing:		
Any Tumors or Cancer:		
Tonsilitis/Frequent Sore Throats:		
Any Joint Problems:		

	YES	NO
Rheumatic/Yellow/Scarlet Fever:		
Acquired Immune Deficiency Syndrome:		
Is Patient Under Medical Care:		
Rheumatism or Arthritis:		
Is the Patient taking any Medications:		
A History of Fainting or Dizziness:		
Does the Patient have a Drug Addiction:		
Is the Patient Pregnant at this Time:		
Measles/Mumps/Chicken Pox:		
Does the Patient Smoke:		
Has the Patient ever had Fever Blisters:		
Is Height & Weight Normal for Age:		
Is the Patient in Good Health:		
Has the Patient had a Physical this Year:		
Has the Patient Reached Puberty:		
If Male, Begun to Shave:		
If Female, Begun to Menstruate:		

	YES	NO
Heart Murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		

	YES	NO
Asthma or Hay Fever:		
Tuberculosis:		
Any Broken Bones:		
Prolonged Bleeding:		
Yellow Jaundice:		
Radiation Therapy:		
Chemical Therapy:		
Blood Transfusions:		
Latex Allergy:		

Is the Patient Allergic to Anything: ____

What: _____

Are you aware of any other disease, condition, or problem not listed above that we should know about:

If Yes, What: _____

Any Unusual Reactions to Any of the Following:

Asprin:____ Sulfa Drugs:____

Barbiturates:____ Other Medications:____

Penicillin:____

List Any Medications Currently Taking:_____

Please Explain:_____

5 DENTAL HISTORY

	Yes	No
Has the Patient Seen a General Dentist in the Last Year:		
Any Pain, Clicking or Discomfort In or Near the Ears:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Have You Been Informed of Missing or Extra Permanent Teeth:		
Are You Aware of Any **"Gum"** Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		
Do You Feel the Patient can Benefit From Orthodontic Treatment:		
Is the Patient Happy with Their **"SMILE"**:		
Does the Patient Want to Improve Their **'SMILE"** and **"BITE"**:		
Would the Patient Mind Wearing **"BRACES"**:		
When are Patient's Teeth Brushed:		
After Breakfast:		
After Lunch:		
After Dinner:		
Before Bed:		

Does the Patient Have or Ever Had Any of the Following Habits:

	Yes	No		Yes	No
Cheek, Tongue or Lip Chewing:			Clenching Teeth:		
Thumb Sucking:			Tongue Thrusting:		
Mouth Breathing:			Grind Teeth:		
Finger Nail Biting:			Speech Problems:		

Has the Patient Been Examined by an Orthodontist Before: ____

If Yes, When: _____

Have Other Members of the Family had Orthodontic Treatment: ____

If Yes , Were You Happy With the Results: ____

If No, Why: _____

Patient's Attitude Toward Braces:

Eagerness: _____

Complacency: _____

Willingness: _____

Antagonism: _____

Who First Noticed the Orthodontic Problem:

Parent: _____

Patient: _____

Dentist: _____

Other: _____

In Your Own Words What is the Orthodontic Problem: _____

What Would you Like Orthodontic Treatment to Accomplish: _____

Patient Signature **Date** **Parent Signature**

6 FOR OFFICE USE ONLY
