



EVANS ORTHODONTICS, P.C.

600 Dakota Dr.
Rapid City, SD 57702

605 342-7777
1-800-559-0899
www.evansortho.com

1. About You

Appointment Date ____/____/____

Name _____
Last First Middle

I prefer to be called _____

Home Address _____

Email Address _____

Birth date ____/____/____ Age _____

SS # _____ Male Female

Single Married Divorced Widowed

Home # _____ Cell # _____

Work # _____ Ext _____

Employer _____

Occupation _____

Where and when are the best times to reach you?

Whom may we thank for referring you?

Is there a staff member at Evans Orthodontics who is primarily responsible for you choosing our office? YES NO

If so, who? _____

2. Spouse Information

His/Her Name _____
Last First Middle

Employer _____

Occupation _____

Work # _____ Cell # _____

SS # _____

Birth date ____/____/____

3. Emergency Contact

Name of nearest relative or friend not living with you

_____ Last First Middle

Relationship _____

Cell # _____ Home # _____

4. Person Responsible for Financial/Account

Name _____
Last First Middle

Relationship to patient _____

Mailing Address _____

Years at this address _____

SS # _____ DOB _____

Home # _____

Work # _____ Cell # _____

Employer _____

Occupation _____ Years Employed _____

I authorize a credit report _____

Signature

5. Orthodontic Insurance

Primary

Insured Name _____

SS or ID # _____ DOB _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Phone # _____

Secondary

Insured Name _____

SS or ID # _____ DOB _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Phone # _____

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records only. Naturally they will be considered confidential and will become part of your permanent dental record.

Height _____ Weight _____

Physician's Name _____

Dentist's Name _____ Date of Last Visit _____

What is your estimation of your general health? (circle one) Good, Fair, Poor

What is your main reason for seeking orthodontic care? _____

If any of the following are answered yes; please give a brief explanation.

- | | | |
|--|-----|----|
| 1. Has Dr. Evans treated others in your family? | YES | NO |
| 2. Has an orthodontist been consulted previously? | YES | NO |
| 3. Have you ever experienced any unfavorable reactions from previous dental or medical care? | YES | NO |
| Please explain: _____ | | |
| 4. Have you had a toothache recently? | YES | NO |
| 5. Is there any history of thumb-sucking, finger-sucking, lip biting or nail biting? | YES | NO |
| 6. Have you visited a dentist within the past year? | YES | NO |
| 7. Do you think your teeth are affecting your general health in any way? | YES | NO |
| 8. Are you worried about receiving orthodontic treatment? | YES | NO |
| 9. Do you have difficulty chewing your food? | YES | NO |
| 10. Do you have any cheek biting problems? | YES | NO |
| 11. Do you have sensitive teeth? | YES | NO |
| 12. Do you have bleeding gums or periodontal "gum" disease? | YES | NO |
| 13. Have you ever had sores in the mouth or on the lips that are slow to heal? | YES | NO |
| 14. Do you have difficulty in opening your mouth widely? | YES | NO |
| 15. Do you have any speech problems? | YES | NO |
| 16. Do you grind your teeth at night? | YES | NO |
| 17. Have you ever chipped a tooth or had a serious blow to the teeth? | YES | NO |
| 18. Have you ever had any injury to your face or jaws? | YES | NO |
| 19. Have you ever been treated for "TMJ"? (jaw joint problems) | YES | NO |
| 20. Do your jaw joints ever click or pop? | YES | NO |
| 21. Has your jaw ever "locked" open or closed? | YES | NO |
| 22. Have you been examined by your physician within the last year? | YES | NO |

23. Are you being treated for any condition by a physician now? YES NO
 What is the condition? _____
24. Have you been taking any medicines within the past year? YES NO
 Please list them here: _____
25. Have you ever been hospitalized or seriously ill? YES NO
 If yes, what was the problem? _____
26. Have you ever had surgery (an operation)? YES NO
 If yes, what was the surgery? _____
27. Are you frequently exhausted, fatigued or ill? YES NO
28. Has there been any change in your general health in the past year? YES NO
29. Have you lost or gained weight in recent months? YES NO
30. Have you ever had a blood transfusion? YES NO
31. Have you ever had X-ray or surgery treatment for a tumor, growth, or other conditions anywhere including your head, mouth or on your lips? YES NO
32. Have you ever had any kind of the following diseases or conditions:
- | | | | | | |
|------------------------------|-----|----|--|-----|----|
| Diabetes (sugar disease) | YES | NO | Hepatitis or Jaundice (yellow skin & eyes) | YES | NO |
| Tuberculosis or Polio | YES | NO | Chicken Pox | YES | NO |
| Measles | YES | NO | Mumps | YES | NO |
| Sexually Transmitted Disease | YES | NO | Immune Disorder or HIV | YES | NO |
| Heart Attack or Stroke | YES | NO | Rheumatic Fever | YES | NO |
| Ulcers | YES | NO | Scarlet Fever | YES | NO |
| Epilepsy | YES | NO | Glaucoma | YES | NO |
33. Have you ever had painful or swollen joints? YES NO
34. Do you currently have a heart murmur or did you ever take the diet drug Phen-Fen? YES NO
 If yes, do you need antibiotic premedication before routine dental work? YES NO
35. Do you have or have you ever had any heart trouble or chest pain on exertion? YES NO
36. Do you have high blood pressure? YES NO
37. Do you bruise easily or bleed for a long time when you cut yourself? YES NO
38. Do you have any blood disorder such as anemia (thin blood)? YES NO
39. Do your ankles ever swell? YES NO
40. Do you have a persistent cough? YES NO
41. Do you have to urinate frequently, either during the day or night? YES NO
42. Are you thirsty much of the time? YES NO
43. Has a doctor ever said you had kidney or bladder disease or infection? YES NO
44. Has a doctor ever said you had liver disease? YES NO
45. Have you ever experienced an unusual reaction to any of the following drugs:
- | | | | | | |
|--------------|-----|----|----------------------|-----|----|
| Penicillin | YES | NO | Iodine | YES | NO |
| Augmentin | YES | NO | Sulfa Drugs | YES | NO |
| Ceclor | YES | NO | Banthine or Atropine | YES | NO |
| Erythromycin | YES | NO | Other Medicine _____ | YES | NO |
46. Have you ever experienced an unusual reaction to a dental anesthetic? ("Novocaine injection") YES NO

- | | | |
|--|-----|----|
| 48. Do you have asthma? | YES | NO |
| 49. Do you have hay fever or other environmental allergies (to food, cat's fur, dust, etc.) ? | YES | NO |
| 50. Do you have hives or skin rash? | YES | NO |
| 51. Do you have an allergy to latex or balloons? | YES | NO |
| 52. Do you have an allergy to nickel or other metals? | YES | NO |
| 53. Do you have numbness in any part of your body? | YES | NO |
| 54. Has any part of your body ever been paralyzed? | YES | NO |
| 55. Do you ever have fits, convulsions or epilepsy? | YES | NO |
| 56. Do you have a tendency to faint? | YES | NO |
| 57. Do you have frequent, severe headaches? | YES | NO |
| 58. Do you have sinus problems? | YES | NO |
| 59. Have you ever been diagnosed with or treated for sleep apnea? | YES | NO |
| 60. Do you have a snoring problem that you are aware of? | YES | NO |
| 61. Do you consider yourself to be a nervous person? | YES | NO |
| 62. Do you often feel unhappy and depressed? | YES | NO |
| 63. Are you easily upset or irritated? | YES | NO |
| 64. Do you have any behavior disorders or mental health problems? | YES | NO |
| 65. Women -- Are you pregnant at this time? | YES | NO |
| 66. Women -- Are you in or have you passed the menopause (change of life)? | YES | NO |
| 67. Women -- Have you had a hysterectomy or ovariectomy? | YES | NO |
| 68. Have you ever or are you now taking a drug of the class Bisphosphonate or Diphosphonates for osteoporosis? Examples: Fosamax, Boniva, Actonel, Zometa or Reclast | YES | NO |
| 69. Is there any other information about your dental or medical health history you feel we should know about? | YES | NO |

I grant permission for Evans Orthodontics to release pertinent information to dental offices.

Signature of Patient _____ Date _____

I have reviewed this history. Dr. Signature _____ Date _____

Updates (date and initial) _____