

Adult Patient Form

Joseph L. Lunsford, D.D.S.

Orthodontic Medical and Dental Questionnaire

(Please Complete and Bring to Appointment)

Patient Information

Name

Dr.

Mr.

Miss

Mrs.

Last

First

Middle

Marital Status

Please Circle

Married

Single

Divorced

Separated

Widowed

Residence

Street

City

State

Zip

How long at this address?

Previous Address (if less than 1 year)

Street

City

State

Zip

Home Phone

Cell Phone

Work Phone

Social Security #

Age

Birthdate

Hobbies/Interests

Occupation

Employer

Of Years Employed

Spouse's Name

Last

First

Middle

Relationship to Patient

Occupation

Employer

Of Years Employed

Work Phone

Social Security #

Birthdate

In Case of Emergency

Name

Relationship to Patient

Home Phone

Cell Phone

Work Phone

Responsible Party Information (If other than above)

Name

Last

First

Middle

Marital Status

Please Circle

Married

Separated

Divorced

Widowed

Residence

Street

City

State

Zip

How long at this address?

Home Phone

Cell Phone

Work Phone

Previous Address (if less than 1 year)

Street

City

State

Zip

Social Security#

Birthdate

Relationship to Patient

Occupation

Employer

Of Years Employed

We offer budgeted plans; therefore our office reviews credit bureau information.

Referral Source

Who may we thank for referring you to this office?

Area or address (if available)

Names of close friends or relatives that are patients of this practice

Insurance Information

If you have any type of dental insurance, please complete the following. If not, turn the page.

Name of Insurance Carrier

Name of Group Plan

Group Number

Phone Number

Address

Employee

Employee Social Security Number

Patient's Relationship to Employee

Is patient covered by another plan? If so, name the plan:

Signature

Dental History

Dentist

Specialty

Address (Street)

(City, State, Zip)

Phone

Period of Treatment

Other Dentist

Specialty

Address (Street)

(City, State, Zip)

Phone

Period of Treatment

Date of last Dental visit

Date of last full mouth X-ray

Date of last completed dental examination

What is your immediate dental and orthodontic concern as you see it?

Please Check yes or no: If yes, please explain.

YES NO

Have you ever had orthodontic treatment? When?

Are you dissatisfied with your teeth and their appearance? Explain

Have you ever had a bad reaction to a dental anesthetic? When?

Have you ever experienced any unfavorable reaction to dentistry?

Have you been previously diagnosed as having a jaw joint condition?

Are you aware of grinding your teeth during your sleep? How often?

Do you have difficulty opening your mouth widely?

Do you have any pain or soreness around your eyes or ears or other parts of your face?

Do you have "tension" headaches? How often?

Are you aware of stiff neck muscles? How often?

Are you aware of clenching your teeth during your daytime hours? How often?

Are you aware of your jaw clenching or popping while eating or yawning? How often?

Are you presently in any dental pain?

Do you have any growths or swellings in your mouth? How long have they existed?

Do you have difficulty swallowing?

Do your gums bleed when you brush your mouth?

Do you avoid brushing any part of your mouth? Why?

Does food catch between your teeth?

Have you ever been told you have gum disease?

Is any part of your mouth sensitive to temperature, pressure, food or drink?

Do you have a burning sensation in your mouth?

Do you have any unpleasant taste or odor in your mouth?

Medical History

Patient:

Height

Weight

Date of last complete medical examination

Family Physician

Specialty

Address (Street, City, State, Zip)

Telephone

Additional Physician

Specialty

Address (Street, City, State, Zip)

Telephone

Please check yes or no: If yes, please give details.

YES NO

Do you PREMEDICATE for any reason?

Do you have a current medical problem? What?

Have you ever had or do you now have any infectious diseases such as Tuberculosis, Hepatitis or AIDS?

Do you have high or low blood pressure? Is it controlled?

Have you had pains in the chest or shortness of breath?

Do your ankles ever swell?

Has your physician ever told you that you are anemic?

Have you ever had a stroke? When?

Have you ever had diabetes? How is it controlled?

Are you subject to fainting or dizziness? When?

Do you have headaches? How often?

Do you have insomnia? How often?

Do you have any nervous disorder? How is it controlled?

Do you take tranquilizers or sedatives? How often?

Do you take Aspirin? How often?

Are you allergic to any medications? What?

Have you been advised not to take any medications? What?

Do you have asthma or hay fever? How is it controlled?

Do you have arthritis? How is it controlled?

Have you ever had a tumor or cancer? How was it treated?

Have you ever had any major operations? What kind?

Have you ever been involved in a serious accident?

Are you taking any medication? Please list:

Taking	For
Taking	For
Taking	For
Taking	For
Taking	For
Taking	For

Have you gained or lost weight within the last year? How much?

Do you become fatigued easily? At what time of day?

Do you frequently not eat breakfast?

Do you have more than one alcoholic drink per day? How many?

Do you use tobacco? How much?

Is your diet medically supervised? For what purpose?

For Women

Are you pregnant? Expected delivery date

Have you reached menopause? If so, are you taking supportive medication?

Patient Notes