Health History Questionnaire

(ADULT PATIENTS)

Date _____

Patient Information

Last name _____ First _____ Middle _____
Patient prefers to be called _____ SSN _____ Birth date _____ Age _____ ❍ Male ❍ Female
Address _____ City _____ Zip _____
Cell phone _____ Email _____ Home _____ Work _____
Previous address (if less than 3 yrs ago) _____
Employer _____ Position _____ Years there _____
Interests/Hobbies _____ Family/friends treated here _____
Whom may we thank for recommending us? _____ Dentist's name _____
What is the primary concern for Dr. Bourne to address? _____

Spouse Information (if applicable)

Last name _____ First _____ Middle _____
SSN _____ Birth date _____ Relationship to you _____
Cell phone _____ Email _____ Home _____ Work _____
Employer _____ Position _____ Years there _____

Orthodontic Insurance Information

Primary policy holder name _____ SSN/ID# _____ Birth date _____
Insurance company _____ Group number _____ Phone number _____
Secondary policy holder name _____ SSN/ID _____ Birth date _____
Insurance company _____ Group number _____ Phone number _____

Dental History

Dentist _____ City _____ Date of last visit _____
Have you been examined/treated by an orthodontist previously? _____
How would you describe your attitude towards orthodontic treatment? _____

Please check any of the following if applicable:

❍ Injuries to the face/mouth/teeth
❍ Thumb, finger, or lip sucking
❍ Tongue thrusting
❍ Speech difficulties
❍ Missing or extra permanent teeth
❍ Teeth removed by extraction
❍ Clenching or grinding
❍ Other _____
❍ Jaw joint sounds or pain/TMJ
❍ Familly history of jaw-size unbalance
❍ Previous difficulty w/dental treatment

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Lake Stevens
9633 Market Place, Ste 104
Lake Stevens, WA 98258
Ph 425.334.4053
Fx 425.334.8387

Jason R. Bourne DDS, MS

Member American Association of Orthodontists

www.bourneorthodontics.com

Marysville
815 State Ave, Ste 3
Marysville, WA 98270
Ph 360.659.0211
Fx 360.658.0716

Medical History

Physician _____ City _____ Phone _____

Medications currently being taken _____

Medication allergies _____ **Are you allergic to latex?** ❍ Yes ❍ No

Other allergies _____

Hospitalizations? Please list procedures and dates _____

Females: Are you pregnant or anticipating pregnancy soon? ❍ Yes ❍ No

Please check any of the following if applicable:

❍ Abnormal bleeding
❍ Anemia
❍ Arthritic/Rheumatoid conditions
❍ Artificial joints/valves/implants
❍ Asthma/respiratory problems
❍ ADHD/sensory problems
❍ Birth defects/hereditary issues
❍ Cardiovascular problems
❍ Cancer/tumor
❍ Diabetes
❍ Dizziness/fainting
❍ Ear/nose/throat/eye disease
❍ Eating disorders
❍ Endocrine/thyroid problems
❍ Epilepsy
❍ Frequent headaches
❍ Gastrointestinal disorders
❍ Heart murmur
❍ Hepatitis/liver problems
❍ Herpes
❍ High blood pressure
❍ HIV/AIDS
❍ Immune system problems
❍ Kidney problems
❍ Mental/emotional problems
❍ Nervous system disorders
❍ Radiation/chemotherapy
❍ Rheumatoid disorders
❍ Sleep apnea
❍ Tuberculosis
❍ Vision/hearing problems
❍ Other _____

Sleep/Airway Issues

Do you tend to be a mouth-breather? ❍ Yes ❍ No

Do you feel well-rested in the morning? ❍ Yes ❍ No

Are you often tired or sleepy during the day? ❍ Yes ❍ No

Do you often snore at night? ❍ Yes ❍ No

Do you awaken multiple times overnight? ❍ Yes ❍ No

Has anyone observed you stop breathing, gasping or struggling to breathe while asleep? ❍ Yes ❍ No

Treatment Motivation

Orthodontic treatment can improve the overall appearance of patients' teeth and faces. Please help us to understand your wishes regarding orthodontic treatment by indicating any of the following that may apply:

How would you like your teeth to change?

❍ Straighten teeth ❍ upper ❍ lower
❍ Move upper teeth ❍ forward ❍ backward
❍ Move lower teeth ❍ forward ❍ backward
❍ Move midline of the upper teeth ❍ left ❍ right
❍ Move midline of the lower teeth ❍ left ❍ right
❍ Move upper teeth up (teeth and gums show too much)
❍ Move upper teeth down (teeth and gums show too little)

If you would you like your face to change, how so?

❍ Move upper lip ❍ forward ❍ backward
❍ Move lower lip ❍ forward ❍ backward
❍ Move upper jaw ❍ forward ❍ backward
❍ Move lower jaw ❍ forward ❍ backward
❍ Move chin to center it ❍ left ❍ right
❍ Other changes desired _____

_____

I have read and understand the above questions. I will not hold the orthodontist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform this practice of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees, and may, at the discretion of this practice, use the services of one or more credit reporting services. If this practice accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover.

Signed _____ **Date** _____