WILSON ORTHODONTICS

Dr. Dustin Wilson, DDS, MS
748 W Stadium Blvd, Suite 102
Jefferson City, MO 65109
Phone: 573-634-5122

ADULT ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name:_____ Preferred name:_____

Date of Birth:_____ Sex: M F E-mail address:_____

Address: Street:_____

City:_____ State:_____ Zip:_____ SS#_____

Home Phone:(____) _____ Work Phone:(____)_____ Cell Phone: (____)_____

Occupation:_____ Employer:_____

Why are you seeking orthodontic treatment? (Please be as specific as possible):

_____

_____

Who may we thank for referring you to our office? _____

Are you the financial responsible party for your treatment? Yes No If no, please complete section below:

Name of responsible party:_____ Preferred name:_____

Address: Street:_____ City:_____

E-mail address:_____ Relationship to patient: _____

Home Phone:(____)_____Work Phone:(____)_____Cell Phone: (____)_____

FAMILY STATUS

Are you married? Yes No

Spouse's name: _____

Spouse's Occupation:_____ Employer:_____

Spouse's Cell Phone: (____)_____ Spouse's Work Phone: (____)_____

INSURANCE INFORMATION

Will you be using dental insurance? Yes No If yes, please provide the following:

Insurance company:_____ Group Number:_____

Telephone Number: (____)_____ Name of Subscriber: _____

Subscriber's Date of Birth:_____ SS#:_____

Employer: _____

Employer Address: _____

DENTAL HISTORY

General Dentist Name:_____City:_____

Date of last dental examination: _____

Have you ever had trauma/damage to the jaws, teeth, or gums? Yes No

Have you ever had orthodontic treatment before? Yes No

Have you had a previous orthodontic consultation? Yes No

Where/When?_____

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Please circle all that apply:

My reason for seeking treatment is: Esthetic Functional Health Related

Please rate the following on a scale from 1-10 (10 being the highest or best):

I think my current state of dental health is a: 1 2 3 4 5 6 7 8 9 10

The current appearance of my teeth is a: 1 2 3 4 5 6 7 8 9 10

The value I place on a beautiful smile is a: 1 2 3 4 5 6 7 8 9 10

My motivation for maintaining and improving my teeth is a: 1 2 3 4 5 6 7 8 9 10

The priority I am currently placing on my smile is a: 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Family Physician:_____ Phone:(____)_____

Address:_____

Are you currently under a physician's care? Yes No

If yes, please explain _____

Are you taking any medicine at this time? Yes No

If yes, please list _____

Are you allergic to any medications? Yes No

If yes, please list _____

Do you have any other allergies? Yes No

If yes, please list _____

Do you need to be premedicated (with antibiotics) for routine dental procedures? Yes No

If yes, please specify and give reason for this need: _____

Have you ever been hospitalized? Yes No

If yes, please explain _____

Females: Are you pregnant? Yes No

Does the patient have or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
□	□	AIDS/HIV+	□	□	Cold Sores	□	□	Injury to head
□	□	Anemia	□	□	Rheumatic Fever	□	□	Kidney Disease
□	□	Arthritis	□	□	Diabetes	□	□	Lung Disease
□	□	Asthma	□	□	Epilepsy/Seizures	□	□	Previous Surgery
□	□	Oral Ulcers	□	□	Hearing Problem	□	□	Psychological Therapy
□	□	Birth Defects	□	□	Heart Condition	□	□	Radiation or cancer therapy
□	□	Bleeding Disorder	□	□	Speech Therapy	□	□	Tonsils/Adenoid Surgery
□	□	Cerebral Palsy	□	□	Hepatitis	□	□	Injury to face/teeth/gums

Do you have any disease, condition, or problem not listed above?

Please explain:_____

Signature:_____ Today's Date:_____

Thanks for your help. We're excited to get to know you better!