MONTGOMERY ORTHODONTICS, P.A.
A beautiful smile begins here
Mary A. Richmond, D.M.D., M.S.

This is a fillable form. *You may either fill this out on your computer and print it, or print it and then fill it out. Please fill it out to the best of your ability. The better we communicate, the better we can care for you. All patient records are kept strictly confidential*

PATIENT QUESTIONNAIRE (for Adult Patient)

Today's Date_____

Patient's Information
Patient's name _____ _____ __
Last First MI
Nickname: _____
Male ☐ Female ☐ Birthdate ___ /___ /___ Age ___
Home address _____
_____ _____ _____
City State Zip
Phone #(___)____-_____Ext____ Home ☐ Cell ☐ Work ☐
Ok to receive text at this phone #? Yes ☐ No ☐
Email_____
Marital status: Single ☐ Married ☐ Widowed ☐
Separated ☐ Divorced ☐
Employer _____
Employer Address: _____
_____ _____ _____
City State Zip
Occupation_____
When and where is the best time to reach you?
_____
Whom may we thank for referring you?
_____
Other family members seen by us: _____
General Dentist _____ _____
Last First

Spouse Information
Name _____ _____
Last First
Phone #(___)____-_____Ext____ Home ☐ Cell ☐ Work ☐
Ok to receive text at this phone #? Yes ☐ No ☐
Email_____
Employer _____
Employer Address: _____
_____ _____ _____
City State Zip
Occupation_____
In the event of an emergency, is there someone who lives near you that we should contact?
Name _____ _____
Last First
Phone #(___)____-_____Ext____ Home ☐ Cell ☐ Work ☐

Person responsible for account
Same as patient? Yes ☐ No ☐ If no, please complete:
Name of responsible party:
_____ _____
Last First
Relationship _____
Billing address _____
_____ _____ _____
City State Zip
Phone #(___)____-_____Ext____ Home ☐ Cell ☐ Work ☐
Ok to receive text at this phone #? Yes ☐ No ☐
Email_____
Employer _____

Employer address _____
_____ _____ _____
City State Zip

Occupation_____

Primary Orthodontic Insurance
Orthodontic Coverage? Yes ☐ No ☐
Dental Coverage? Yes ☐ No ☐
Insurance Co. Name _____
Insurance Co. Phone # (___)____-_____
Group # _____
Policy # or Social Security # _____
Policy Owner's Name
_____ _____
Last First
Relationship to Patient _____
Policy Owner's Birthdate ___ / ___ / ___
Policy Owner's Employer
_____

Secondary Orthodontic Insurance
Orthodontic Coverage? Yes ☐ No ☐
Dental Coverage? Yes ☐ No ☐
Insurance Co. Name _____
Insurance Co. Phone # (___)____-_____
Group # _____
Policy # or Social Security # _____
Policy Owner's Name
_____ _____
Last First
Relationship to Patient _____
Policy Owner's Birthdate ___ / ___ / ___

Medical History
Do you have a personal physician? Yes ☐ No ☐
Physician's Name _____ _____
Last First
Physician's Phone # (___)____-_____
Your current physical health is Good ☐ Fair ☐ Poor ☐
Are you currently under care of a physician? Yes ☐ No ☐
If yes, please explain _____
Are you taking any prescription or over-the-counter medication? Yes ☐ No ☐ If yes, please explain _____
_____
For women, are you pregnant? Yes ☐ No ☐

Continued on next page

Medical History Continued

Your name _____ _____ ___
Last First MI

Have you ever had any of the following medical problems?

Y ☐ N ☐ Abnormal bleeding	Y ☐ N ☐ Blood Transfusion
Y ☐ N ☐ Allergies to any drugs	Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Allergic to Latex/Metals	Y ☐ N ☐ HIV+/AIDS
Y ☐ N ☐ Allergic to Plastic	Y ☐ N ☐ Asthma
Y ☐ N ☐ Any Hospital Stays	Y ☐ N ☐ Diabetes
Y ☐ N ☐ Any Operations	Y ☐ N ☐ Cancer
Y ☐ N ☐ Kidney/Liver Problems	Y ☐ N ☐ Arthritis
Y ☐ N ☐ Psychological Counseling	Y ☐ N ☐ Anemia
Y ☐ N ☐ Congenital Heart Defect	Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Rheumatic/Scarlet Fever	Y ☐ N ☐ Hearing Impairment
Y ☐ N ☐ Epilepsy/Seizures/ Fever	Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Handicaps/Disabilities	Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Prosthetic Valve	Y ☐ N ☐ Prosthetic Hips
Y ☐ N ☐ Osteoporosis	

Height _____ Weight _____
Please list any medical conditions you have ever had
_____
_____
_____

Are you allergic to any of the following:

Y ☐ N ☐ Aspirin	Y ☐ N ☐ Dental Anesthetics
Y ☐ N ☐ Metals or plastics	Y ☐ N ☐ Erythromycin
Y ☐ N ☐ Codeine	Y ☐ N ☐ Latex
Y ☐ N ☐ Penicilin	Y ☐ N ☐ Tetracycline
Y ☐ N ☐ Other, please list _____	
Habits _____	

Dental History

Name of Dentist _____ _____
Last First
Dentist Phone # (___)____-_____
Date of last visit to dentist (approximate) ___ / ___ / ___
Date of last dental X-rays taken (approx) ___ / ___ / ___

What are the main concerns you would like orthodontics to accomplish? _____
_____
Have you ever had or been evaluated for orthodontic treatment? Yes ☐ No ☐
Have you had a serious or difficult problem associated with any previous dental work? Yes ☐ No ☐ If yes, please explain_____

Have you ever had injury to your:

Yes ☐ No ☐ Face	Yes ☐ No ☐ Mouth
Yes ☐ No ☐ Teeth	Yes ☐ No ☐ Chin

Have your adenoids or tonsils been removed? Yes ☐ No ☐
Have you been informed of any missing or extra permanent teeth? Yes ☐ No ☐ Not sure ☐
Do you now have or have you ever had any pain/tenderness/ clicking/popping in your jaw joint (TMJ/TMD)? Yes ☐ No ☐

Do you like your smile? Yes ☐ No ☐

Do you have dental implants? Yes ☐ No ☐

Have you been treated for periodontal disease? Y ☐ N ☐

Do your gums ever bleed? Yes ☐ No ☐

Do you generally breathe through your mouth? Y ☐ N ☐
If yes, while awake ☐, or while asleep ☐

Do you need to take antibiotics before dental procedures? Yes ☐ No ☐
Your current dental health is: Good ☐ Fair ☐ Poor ☐

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with informed consent.

_____ _____
Signature Date

I understand that I am responsible for full payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover

_____ _____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and ADA as well as HIPAA privacy regulations

Montgomery Orthodontics, P.A.
Mary A. Richmond, D.M.D., M.S.
Montgomery Knoll
83 Tamarack Circle, Skillman, NJ 08558
Phone: 609-688-1611
www.montgomeryortho.com

MONTGOMERY ORTHODONTICS, P.A.
A beautiful smile begins here