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 Child Patient)

Today's Date_____

Patient's Information
Patient's name _____ _____ __
Last First MI
Nickname: _____
Male ☐ Female ☐ Birthdate ___ / ___ / ___ Age ___
School _____ Grade _____
Hobbies/Sports _____
Phone # (___)____-_____ Home ☐ Cell ☐
Email _____
Home address _____
_____ _____ _____
City State Zip

Person Responsible for Making Appointments
Name _____ _____
Last First
Phone #(___)____-____Ext ___Home ☐ Cell ☐ Work ☐
Ok to receive text at this phone #? Yes ☐ No ☐
Email_____

Who is Accompanying your Child?
Name _____ Relation _____
Do you have legal custody of this child? Yes ☐ No ☐
Whom may we thank for referring you? _____
List siblings with age: _____
_____
Parents' marital status: Single ☐ Married ☐ Widowed ☐
Separated ☐ Divorced ☐
Is patient living with both parents? Yes ☐ No ☐
If no, with whom is patient living? _____

Mother's Information
Natural Mother ☐ Step Mother ☐ Guardian ☐
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_____

Father's Information
Natural Father ☐ Step Father ☐ Guardian ☐
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_____

Person Responsible for Account
Name _____ _____
Last First
Relationship _____

Billing address _____

_____ _____ _____
City State Zip

Phone #(___)____-____Ext ___Home ☐ Cell ☐ Work ☐
Ok to receive text? 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 DOB _____

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 DOB _____

Medical History

Patient's name _____ _____ __
Last First MI

Has the patient 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

Height _____ Weight _____
Please discuss any medical problem the patient has
_____
_____
Patient's Physician _____
Does patient have tendency to colds? Yes ☐ No ☐
Sore throats? Yes ☐ No ☐ Ear infections? Yes ☐ No ☐
Difficulty breathing? Yes ☐ No ☐
Is patient currently under care of a physician? Yes☐ No☐
If yes, for what? _____
Has puberty begun (for boys/girls)? Yes ☐ No ☐
Has menstruation begun (girls)? Yes ☐ No ☐
Does patient need to take antibiotics before dental procedures? Yes ☐ No ☐
Please describe your child's current physical health
Good ☐ Fair ☐ Poor ☐

Please list all drugs patient is currently taking: _____
_____
Please list all allergies patient (e.g., medications; antibiotics, foods, metals) _____
_____

Dental History
Patient's 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? _____
_____
Has patient ever had or been evaluated for orthodontic treatment? Yes ☐ No ☐
Has patient ever had injury to his or her:

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

Musical instruments played: _____

Have adenoids or tonsils been removed? Yes ☐ No ☐

Has patient been informed of any missing or extra permanent teeth? Yes ☐ No ☐ Not sure ☐

Has patient ever had any pain / tenderness / clicking / popping in his or her jaw joint (TMJ/TMD)? Yes ☐ No ☐

Does patient brush his or her teeth daily? Yes ☐ No ☐

Does patient floss his or her teeth daily? Yes ☐ No ☐

Did patient have any of the following habits?

Clenching/grinding teeth Yes ☐ No ☐	Nail biting Yes ☐ No ☐
Nursing bottle habits Yes ☐ No ☐	Tongue thruster Yes ☐ No ☐
Speech problems / therapy Yes ☐ No ☐	Lip sucking / biting Yes ☐ No ☐
Thumb / finger sucking Yes ☐ No ☐	Mouth breather Yes ☐ No ☐

Patient's expected cooperation level:
Excellent ☐ 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 my child may need

_____ _____
Signature of Parent or Guardian 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 of Parent or Guardian 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

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