



# GOOD ORTHODONTICS

Board Certified Specialists in Orthodontics and Facial Orthopedics  
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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Prefers to be addressed by: \_\_\_\_\_ Soc Sec# \_\_\_\_\_ Referred by: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Hobbies & Interests: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated Spouse's Name: \_\_\_\_\_

Spouse Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Children: Names \_\_\_\_\_ Birthdates \_\_\_\_\_ Ages \_\_\_\_\_

Names \_\_\_\_\_ Birthdates \_\_\_\_\_ Ages \_\_\_\_\_

Person Responsible for account:  Self  Spouse  Other: \_\_\_\_\_

Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

## DENTAL INSURANCE

Primary Insurance Co: \_\_\_\_\_ Gr.#: \_\_\_\_\_ Ortho Coverage:  Yes  No

Insureds Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ Gr.#: \_\_\_\_\_ Ortho Coverage:  Yes  No

Insureds Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Other Insurance Information: \_\_\_\_\_

## DENTAL HISTORY

Patient's Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

1. Have there been any injuries to the face, mouth or teeth?  YES  NO

2. Have you had or do you presently have any of the following habits?  
 Thumb or finger sucking  Lip biting  
 Clenching  Nail biting  Tongue Thrusting  
 Grinding of teeth at night/Bruxing  
 NO  Mouth Breathing  Other: \_\_\_\_\_

3. Have you been informed of any missing or extra permanent teeth?  YES  NO

4. Are you aware of sores, lumps or irritated areas in the mouth?  YES  NO

5. Do your gums ever bleed?  YES  NO

6. Has an orthodontist been consulted previously?  YES  NO  
Name: \_\_\_\_\_ Date: \_\_\_\_\_

7. Have you ever been treated for:  Bad Bite  TMJ  Periodontal Disease  
If so, by whom?:  NO

8. Do you have any speech problems?  YES  NO

9. Are you frightened or anxious about orthodontic treatment?  YES  NO

10. Are you concerned about the appearance of your teeth?  YES  NO

11. Is there anything you would like to change about your smile?  YES  NO  
If so, what? \_\_\_\_\_

12. What aspect of dental treatment are you most concerned with?  Quality  Cost  Discomfort  Time

13. Reason for consultation: \_\_\_\_\_

14. Has there ever been any orthodontic treatment for any other member of the family?  YES  NO  
Sons (Dr. \_\_\_\_\_) Daughters (Dr. \_\_\_\_\_) Brothers (Dr. \_\_\_\_\_) Sisters (Dr. \_\_\_\_\_)

15. Are you satisfied with the results?  YES  NO

## MEDICAL HISTORY

1. What is the name of your family physician?	Date of last physical:
2. What is your approximate height?	Weight?
3. Is your general health good at this time?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Are you under the care of a physician at this time?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Explain:	
5. Are you taking any medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name(s) and purpose:	
6. Do you have any bleeding problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Are you allergic to any medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name:	
8. Have you had your tonsils removed?	<input type="checkbox"/> YES <input type="checkbox"/> NO Age: _____
9. Have you had your adenoids removed?	<input type="checkbox"/> YES <input type="checkbox"/> NO Age: _____
10. Have you ever had a serious illness or been hospitalized?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Explain:	
11. Do you have any special problems not listed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Explain:	
12. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, antibiotic name and method:	
13. WOMEN:	
Are you pregnant or considering pregnancy during the next 2 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you currently taking medication for birth control?	<input type="checkbox"/> YES <input type="checkbox"/> NO
14. Do you smoke or use tobacco?	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. Have you taken any diet medication? (fen-phen)	<input type="checkbox"/> YES <input type="checkbox"/> NO

### DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Endocarditis	<input type="checkbox"/> <input type="checkbox"/> Respiratory Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> <input type="checkbox"/> Heart Condition	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> <input type="checkbox"/> Heart Angina	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction
<input type="checkbox"/> <input type="checkbox"/> Heart Attack (coronary)	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease	<input type="checkbox"/> <input type="checkbox"/> Headaches
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Herpes (oral-cold sores)	<input type="checkbox"/> <input type="checkbox"/> Earaches
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Blood Disorders	<input type="checkbox"/> <input type="checkbox"/> Impaired Hearing
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Inflammatory Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Hyperactive
<input type="checkbox"/> <input type="checkbox"/> Heart Surgery; date _____	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Handicap - Disabilities
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Jaw Clicking
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> Prosthetic (artificial) Joint	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain
<input type="checkbox"/> <input type="checkbox"/> X-Ray/Radiation (cancer) Therapy	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> <input type="checkbox"/> AIDS or H.I.V. Positive	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Emotional Problems
<input type="checkbox"/> <input type="checkbox"/> Sickle Cell	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Latex Allergy
<input type="checkbox"/> <input type="checkbox"/> Hemophiliac	<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis		_____
<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizure/Convulsion		_____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION OR INFORMATION NOT DISCLOSED. I also authorize the dental staff to perform the necessary dental services I may need.

Signature of patient

Signature of Orthodontist

*I realize I am responsible for updating this office of any changes regarding my health status.*

Update _____	Initial _____
Update _____	Initial _____
Update _____	Initial _____
Update _____	Initial _____
Update _____	Initial _____

#### NOTES:

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