SALMON ORTHODONTICS

Professional Corporation

Dr. Marlin Salmon and Dr. Deborah deSa

Practice Limited to Orthodontics for Children and Adults

IN ORDER TO PERFORM A MORE COMPLETE SERVICE FOR OUR PATIENTS, WE ASK YOUR COOPERATION IN COMPLETING THIS QUESTIONNAIRE.

PATIENT INFORMATION

Patient Name _____ M □ F □

Soc. Sec. # _____ Nickname _____ Birthdate _____

Address _____ Tel. # _____
Street City/State Zip

How long at this address? _____If less than 3 years, previous address _____How long? _____

E-Mail Address _____ Cell # _____

Do you wish to have E-mail appointment reminders? Yes □ No □

Do you wish to have Text Message appointment reminders? Yes □ No □

Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

Occupation _____ Business Telephone #_____

Business Name and Address_____
Name Street City/State Zip

Whom may we thank for referring you? _____

Dentist _____ Address _____
Street City/State Zip

Physician _____ Address _____
Street City/State Zip

Name of Spouse _____ Spouse Employed by_____

Spouses Business Telephone #_____

Person(s) Financially Responsible _____ Relationship _____

Insurance covering orthodontics _____ Carrier _____

ORTHODONTIC INFORMATION

1. Reason for orthodontic consultation: _____
2. Previous treatment - patient or others in immediate family:

   Yes □ No □ If yes, who? _____

   With what results? _____Excellent _____ Good _____Poor

3. Have you had a previous orthodontic consultation?

Yes □ No □ If yes, with whom? _____

4. What do you consider to be the main benefits of orthodontic correction?

_____Cosmetic _____ Functional _____Psychological/Emotional Other _____

Which are factors in this instance? _____

MEDICAL HISTORY

1. Present state of health: _____Excellent _____ Good _____Fair _____Poor
2. Currently under physician's care:

Yes □ No □ Why? _____

_____

3. Currently taking medications including dietary supplements:

Yes □ No □ What? _____

_____

4. Is there any **patient** history: (If you answer **yes** to any of the following questions, please explain to the right of the question.)

Yes □ No □ Facial accidents? _____
Yes □ No □ Facial operations? _____
Yes □ No □ Environmental allergies? Food allergies?_____
Yes □ No □ Allergies to medication? _____
Yes □ No □ Emotional disorders? _____
Yes □ No □ Vision impairment? _____
Yes □ No □ Hearing problems? _____
Yes □ No □ Tonsillitis? _____
Yes □ No □ Speech problems? _____
Yes □ No □ Blood disorders? _____
Yes □ No □ Immune System Disorders?_____
Yes □ No □ Birth defects? _____
Yes □ No □ Asthma? _____
Yes □ No □ Anemia? _____
Yes □ No □ Diabetes? _____
Yes □ No □ Hepatitis? _____
Yes □ No □ Rheumatic Fever? _____
Yes □ No □ Epilepsy? _____
Yes □ No □ Heart Disease problems including murmurs? _____
Yes □ No □ Liver or Kidney disease? _____
Yes □ No □ TMJ (jaw joint problems)? _____
Yes □ No □ Joint problems? _____
Yes □ No □ Arthritis?_____
Yes □ No □ Tobacco use?_____
Yes □ No □ Osteoporosis? Bisphosphonate medications?_____

5. Serious illness other than usual childhood disorders? _____

_____

6. Have you ever been hospitalized?

Yes □ No □ If yes, for what and the date: _____

_____

7. Are you under psychological guidance?

Yes □ No □ If yes, for what? _____

DENTAL HISTORY

1. When was your last visit to your general dentist? _____

2. Have you had:

   Yes □ No □ Regular dental check-ups?_____
   Yes □ No □ X-rays?_____
   Yes □ No □ Extractions? _____
   Yes □ No □ Impressions?_____

3. Have you ever lost or chipped any teeth?

   Yes □ No □ If yes, explain the circumstances _____

4. Oral hygiene habits: _____Good _____ Average _____Poor

5. Intake of sweets: _____High _____Moderate _____Low

6. Have you ever received a blow to the teeth or jaws?

   Yes □ No □ If yes, please explain: _____

   _____

7. Indicate habits, past or present, relating to the mouth or face:

   Yes □ No □ Thumb □ Finger □ Object □ sucking? _____
   Yes □ No □ Mouth breathing? _____
   Yes □ No □ Lip biting? _____
   Yes □ No □ Tongue thrust (reverse swallow)? _____
   Yes □ No □ Chewing habits? _____
   Yes □ No □ Nail biting? _____
   Yes □ No □ Postural habits? _____
   Yes □ No □ Sleeping habits (blanket sucking)? _____
   Yes □ No □ Tooth grinding/clenching? _____
   Yes □ No □ Poor speech habits? _____

8. Is there any hereditary background (familial tendency) which might contribute to this orthodontic problem?

   _____

   _____

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting service.

Signed _____ Date _____