



Victoria Lynskey
ORTHODONTIST D.M.D., M.D.S.

ADULT ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name: _____ Preferred name: _____
Last First MI

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

Address: Street: _____ City: _____

State: _____ Zip: _____ Home Telephone: () _____

Cell: () _____ Work: () _____

Occupation: _____ Employer: _____

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

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

FAMILY STATUS

Are you married? Yes No Spouses name: _____

Spouse's Occupation: _____ Employer: _____

Spouse's cell phone: () _____ 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: _____ Employer: _____

Subscriber's Date of Birth _____ SS# _____

DENTAL HISTORY

General Dentist: _____ Phone: () _____

Address: _____

Date of last dental examination: _____

Have you ever had orthodontic treatment before? Yes No

Have you had a previous orthodontic consultation? Yes No

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

Do you have or have you ever had any of the following?

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

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

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

Signature: _____ Today's Date: _____