DOYLE ORTHODONTICS
RENEE E.DOYLE DMD MS

Dr. Renee Doyle
107 North Main Suite 2B
Columbia, IL 62236

ADULT ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name:_____ Preferred name:_____
Date of Birth:_____ Sex: M F E-mail address:_____
Address: Street:_____
City:_____ State:_____ Zip:_____
Home Phone:(____) _____ Work Phone:(____) _____ Cell Phone: (____) _____
Occupation:_____ Employer:_____
Why are you seeking orthodontic treatment? (Please be as specific as possible):
_____
_____
Who may we thank for referring you to our office? _____
I am interested in the following (check all that apply) □ Metal Braces □ Ceramic Braces □ Invisalign □ Other

FAMILY STATUS

Are you married? Yes No
Spouses name: _____
Spouse's Occupation:_____ Employer:_____
Spouse's Cell Phone: (____)_____ Spouse's 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:_____
City:_____
Date of last dental examination: _____
Have you ever had trauma/damage to the jaws, teeth, or gums? Yes No
Have you ever had orthodontic treatment before? Yes No
Have you had a previous orthodontic consultation? Yes No
Where?_____

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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:(____)_____

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

Does the patient have or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV+	☐	☐	Cold Sores	☐	☐	Injury to head
☐	☐	Anemia	☐	☐	Rheumatic Fever	☐	☐	Kidney Disease
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Lung Disease
☐	☐	Asthma	☐	☐	Epilepsy/Seizures	☐	☐	Previous Surgery
☐	☐	Oral Ulcers	☐	☐	Hearing Problem	☐	☐	Psychological Therapy
☐	☐	Birth Defects	☐	☐	Heart Condition	☐	☐	Radiation or cancer therapy
☐	☐	Bleeding Disorder	☐	☐	Speech Therapy	☐	☐	Tonsils/Adenoid Surgery
☐	☐	Cerebral Palsy	☐	☐	Hepatitis	☐	☐	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:_____