Dr. Renee Doyle
106 Veterans Parkway
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?____

DOYLE ORTHODONTICS
RENEE E.DOYLE DMD MS

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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:_________________