DOYLE ORTHODONTICS
RENEE E.DOYLE DMD MS

Dr. Renee Doyle
106 Veterans Parkway
Columbia, IL 62236

CHILD ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name:_____ Preferred name:_____
Date of Birth:_____ Sex: M F E-mail address:_____
Address: Street:_____
City:_____ State:_____ Zip:_____ Telephone: (____)_____
Name of School:_____ Grade level:_____
Hobbies/Interests: _____

Name of responsible party:_____ Preferred name:_____
Address: Street:_____ City:_____
E-mail address:_____
Home Phone:(____)_____Work Phone:(____)_____ Cell Phone: (____)_____
Why are you and your child 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

Father's name:_____ Cell phone: (____)_____
Occupation:_____ Employer:_____ Work Phone: (____)_____
Mother's name: _____ Cell phone: (____)_____
Occupation:_____ Employer:_____ Work Phone: (____)_____
Marital Status of parents:_____ Is the patient adopted? Yes No
Brother & Sisters:_____

INSURANCE INFORMATION Will you be using dental insurance? Yes No
Insurance company:_____ Group Number:_____
Telephone Number: (____)_____
Name of Subscriber: _____ Employer:_____
Subscriber's Date of Birth_____ SS#_____

DENTAL HISTORY

General Dentist:_____ Phone:(____)_____
Date of last dental examination: _____
Has another member of the family had orthodontic treatment? Yes No Who?
Has this patient had a previous orthodontic consultation? Yes No Where?
Has the patient ever had trauma/damage to the teeth, jaws, or gums? Yes No

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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

Does the patient have any disease, condition, or problem not listed above?

Please explain: _____

DOES/DID THE PATIENT:

Grind his/her teeth at night? Yes No Brush his/her teeth ☐ Often ☐ Occasionally ☐ Reluctantly

Suck thumb, finger, pacifier? Yes No If yes, what age was the habit discontinued? _____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT

Is the patient aware of the problem? Yes No

The patient's interest in having treatment is: ☐ Excited ☐ Willing if necessary ☐ Reluctant

BEHAVIOR ASSESSMENT Personality (check any that apply):

☐Calm ☐Nervous ☐Quiet ☐Shy ☐Outgoing ☐Uncooperative ☐Cooperative
☐Confident ☐Afraid ☐Emotional disturbance

Progress at school when compared to children of the same age: ☐ Behind ☐ Same Level ☐ Advanced

GROWTH STATUS:

Height:_____ Weight:_____

Females: Has the patient started her menstruation? Yes No If yes, what age? _____

Males: Has the patient yet undergone voice changes? Yes No Facial hair growth? Yes No

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

Signature of the person completing this form: _____

Relationship to the patient:_____ Today's Date:_____

Phone: 618.281.5896 • Fax: 618.719.2467 • web: www.doyleorthodontics.com• email: info@doyleorthodontics.com