Patient Information Questionnaire

Thank you for selecting our office! Dr. Rigali and his staff are committed to providing you with highly personalized care and service beyond your expectations. At your initial visit (60-75 minutes) we will have a chance to meet each other and discuss your concerns. We will conduct a comprehensive evaluation and make recommendations to you regarding the timing and appropriateness of orthodontic treatment.

This questionnaire will help us understand your concerns and your medial and dental histories that may influence your orthodontic problems and eventual treatment options. Please complete the entire questionnaire and bring it with you to your appointment. Also, please bring with you any other information that may allow us to address your special needs.

Please provide us with the following information:

Patient:

Last Name ____________________________ First ______________________ MI ____ Nickname ______________ Sex: □ M □ F Date of Birth _____/_____/____

Address ____ Home Phone _______________________________________

School/Employer ________________________________ Grade/Dept. _____________________________________ Years with employer (if adult) ____________

Marital Status (or parents' marital status if a child): □ Single □ Married □ Separated □ Widowed □ Divorced Email : _________________________________

City State Zip

Father/Husband:

Last Name ________________________________ First ___________________________________ Date of Birth _____/_____/____

Address (if different) ____ Home Phone ____________________________________

City ____ State___________________________ Zip_____________ Years lived at this address _____________

Employer ____ Years with this Employer ________________ Soc. Sec. No. _________________

Work/Cell Phone ___________________/______________________ Email _________________________________ OK to contact at office? □Yes □ No

Mother/Wife:

Last Name __________________________________ First _______________________________________ Date of Birth _____/_____/____

Address (if different) ____ Home Phone ____________________________________

City ____ State___________________________ Zip_____________ Years lived at this address _____________

Employer ____ Years with this Employer ________________ Soc. Sec. No. _________________

Work/Cell Phone _____________________/________________________ Email _________________________________ OK to contact at office? □Yes □ No

Financially Responsible Person:

(Check all who will paying on the account) □ Self □ Father □ Mother □ Other (complete below only if other)

Other name ____ Relation to patient ______________________________ Soc. Sec. No. ___________________

Address (if different) ____ Years lived at this address _____________

Employer ____Years with this Employer _________________ OK to contact at office? □Yes □ No

Work/Cell Phone ____Email ____

Dental Insurance Information:

City State Zip

Name of Insured: □ Patient □ Father □ Mother □ Guarantor ____

Insurance Company ____ ID # ______________________ Soc. Sec. No. ___________________

Insurance Company Phone ________________________________ Address ____ Date of Birth _____/_____/____

Secondary Insurance ____ ID# ____

Insurance Company ____ Soc Sec No. ________________________________ Date of Birth _____/_____/____

Insurance Company Phone ____ Address ____

In case we can't reach you whom may we contact? Person's name _______________________ Relationship _____________________ Phone ________________

Paul H. Rigali, D.D.S., P.C. *Diplomate of the American Board of Orthodontics*
217 103D Maxham Meadow Way • Suite 3D, Sunset Farm • Woodstock • Vermont •05091
Phone: 802-432-1087 • **Fax**: 802-432-1088
Email: orthodontix@rigaliorthodontix.com • **Website**: rigaliorthodontix.com

Medical History

Name of Family Physician: ___________________________ Date of last visit to physician: ________________
Are there any medical specialists you see regulary? Specialty: ________________________________
Date of last complete physical exam: ___________________ Examining doctor: _________________________

Has this patient been advised by a physician that they require an antibiotic prior to dental treatment? □ No, if □ Yes,
Antibiotic _________________________________ How is antibiotic given? ___________________________________

This patient's general health at this time is? □ Good, □ Fair, □ Poor, Comment ____
Is this patient Presently under the care of a physician? □ No, if □ Yes, For what? ____
Is this patient presently taking medications? □ No, if □ Yes, Which medications? _______________________________________
Has this patient had tonsils or adenoids removed? □ No, if □ Yes, □ Tonsils (on date ___________) □ Adenoids (on date ___________)
Does this patient have a Chronic Illness? □ No, if □ Yes, Comment ____
Has this patient ever had a serious illness? □ No, if □ Yes, Comment ____
Has this patient ever been Hospitilized? □ No, if □ Yes, For what? ____
Is this patient allergic to antibiotics (penicillin, etc)? □ No, if □ Yes, Which medications? _______________________________________
Does this patient have anesthetic reactions? □ No, if □ Yes, □ Local, □ General ____
Is this patient allergic to anything else? □ No, if □ Yes, What? □ Sulfa Drugs □ Aspirin □ Ibuprofen □ Environmental □ Metals
□ Plastics □ Latex Comment: ____

Does this patient now have, or ever had any of the following problems?

□ No □ Yes Glaucoma
□ No □ Yes Heart Problems
□ No □ Yes Intestinal blockage
□ No □ Yes Colitis
□ No □ Yes Kidney problems
□ No □ Yes Urinary Tract blockage
□ No □ Yes Esophagitis
□ No □ Yes Wear contact lenses
□ No □ Yes Damaged or Artificial Heart Valve, including Heart Murmur or Rheumatic heart disease
□ No □ Yes Cardiovascular Disease
□ No □ Yes Abnormal Bleeding
□ No □ Yes Blood Transfusion
□ No □ Yes Anemia
□ No □ Yes Diabetes
□ No □ Yes Liver Disease (Hepatitis type ________)
□ No □ Yes Tonsillitis
□ No □ Yes Stomach Ulcers
□ No □ Yes Tumor or Growth treatment
□ No □ Yes Sinus trouble
□ No □ Yes AIDS or HIV positive
□ No □ Yes Thyroid problems
□ No □ Yes Lung problems (asthma, bronchitis, etc)
□ No □ Yes Tuberculosis
□ No □ Yes Lived with tuberculin person
□ No □ Yes Sexually transmitted disease
□ No □ Yes Epilepsy, Stroke, etc.
□ No □ Yes Mental Health problems
□ No □ Yes Immune System problems
□ No □ Yes Arthritis/Inflammatory Rheumatism
□ No □ Yes Female (is patient pregnant?)
□ No □ Yes Female (taking birth control pills?)
□ Other ________________________________

Please comment on any yes responses ____
____

Do you breathe through your □ Nose □ Mouth □ Both
□ No □ Yes Do you have environmental allergies?
□ No □ Yes Fatigue during day?
□ No □ Yes "Dose off" during day?
□ No □ Yes Snore at night?
□ No □ Yes Does snoring affect your bed partner?
□ No □ Yes Does your snoring affect others in the house?
□ No □ Yes Have you ever been told that you stop breathing between snores?
□ No □ Yes Have you been suddenly awakened by your own snoring?
□ No □ Yes Do you awaken from sleep with a gasping or chocking sensation?

Patient Growth History
What is this patient's Height ______ Ft. ______ In.
Patient's present age? ______ Years, ______ months
Is child adopted? □ No □ Yes
Any recent signs of increased growth? □ No □ Yes
If a *BOY*, has voice changed? □ No □ Yes
If a *GIRL*, has she started menstruation? □ No □ Yes If Yes When ____________
MOTHER'S present height? ______ Ft. ______ In.
FATHER'S present height? ______ Ft. ______ In.
Comments ____

Patient's Family History of:	if **Yes** to any, which family member	Comments on Family Histories:
□ No □ Yes Allergies	__________________	__________________
□ No □ Yes Arthritis	__________________	__________________
□ No □ Yes Mouth breathing	__________________	__________________
□ No □ Yes Snoring	__________________	__________________
□ No □ Yes Sleep Apnea	__________________	__________________
□ No □ Yes Problem with Jaw Joints (TMD)	__________________	__________________
□ No □ Yes Facial Pain	__________________	__________________
□ No □ Yes Prior Orthodontics with Jaw Surgery	__________________	__________________

Paul H. Rigali, D.D.S., P.C. *Diplomate of the American Board of Orthodontics*
217 103D Maxham Meadow Way • Suite 3D, Sunset Farm • Woodstock • Vermont •05091
Phone: 802-432-1087 • **Fax**: 802-432-1088
Email: orthodontix@rigaliorthodontix.com • **Website**: rigaliorthodontix.com

Dental History

Name of Family Dentist: ___________________________________ Date of last dental visit: __________________

How many times a day do you **BRUSH?** □ 0 □ 1 □ 2 □ 3+ How many times a day do you **FLOSS?** □ 0 □ 1 □ 2+

Why is the patient seeking orthodontic treatment? □ Appearance of teeth □ Oral Function
□ Crowding/Spacing □ Protrusion □ Facial Esthetics □ TMJ Pain/Dysfunction □ Self-esteem

Comments: ____

Why are the parents seeking orthodontic treatment? □ Appearance of teeth □ Oral Function
□ Crowding/Spacing □ Protrusion □ Facial Esthetics □ TMJ Pain/Dysfunction □ Self-esteem

Comments: ____

How did you hear about us? □ Family Member □ Friend □ Primary Care Dentist
□ Medical Professional □ Other Dental Professional □ Other

Name(s): ____

Has this patient been examined by another orthodontist? □ No, if □ Yes, Date: ___________, Name of orthodontist _______________________
Has this patient ever had *orthodontic* treatment (braces)? □ No, if □ Yes, Date: ___________, Name of Dentist ___________________________
Has this patient been treated for TMJ problems? □ No, if □ Yes, Date: ___________, Name of Dentist ___________________________
Has this patient been treated for gum disease? □ No, if □ Yes, What kind of treatment ______________________________________
How does the patient breathe? □ Nose □ Mouth □ Both □ Snoring □ Sleep Apnea
Does the patient have any of the following oral habits? □ No, if Yes, □ Thumb/finger Sucking □ Tongue Thrusting
□ Other: ____
Does this patient have any TMJ (jaw joint) Symptoms? □ No, if □ Yes □ Grinding □ Clenching □ Jaw Joint Noises □ Headaches/Neckaches
□ Jaw Joint Pain □ Facial or Ear Pain □ Locking or difficulty moving of Jaws □ Dental/Facial Trauma □ Arthritis

Does this patient have any Missing/Extra permanent teeth? □ No, if □ Yes, Comment: ____
Does this patient typically have bleeding gums? □ No, if □ Yes, Comment: ____
Does this patient have sores, lumps, or irritated tissue in the mouth? □ No, if □ Yes, Comment: ____
Has this patient had any *injuries* to his/her teeth? □ No, if □ Yes, @ Age: _______ □ Chipped □ Broken □ Lost
Has the patient had any *injuries* to his/her face or jaws or mouth? □ No, if □ Yes, @ Age: _______ Comment: ________________________
Does this patient have any Speech Problems? □ No, if □ Yes, Comment: ____
Are there any other comments about this patient's dental history? □ No, if □ Yes, Comment: ____

Patient and Family Concerns:
Is this patient anxious about having orthodontic treatment? □ No, if □ Yes, Comment: ____
Do other family members have concerns about orthodontic treatment? □ No, if □ Yes, Comment: ____

Family History of orthodontic treatment:
Mother: □ No, if □ Yes: Dentist _______________________ Were you satisfied with the results? □ Yes □ No _______________________________________
Father: □ No, if □ Yes: Dentist _______________________ Were you satisfied with the results? □ Yes □ No _______________________________________
Sister: □ No, if □ Yes: Dentist _______________________ Were you satisfied with the results? □ Yes □ No _______________________________________
Brother: □ No, if □ Yes: Dentist _______________________ Were you satisfied with the results? □ Yes □ No _______________________________________
Comments: ____

☺ If your dentist has taken new **full mouth** or **panoramic x-rays** in the past six months, please bring them with you to the exam.
☺ If you have had **orthodontic records** taken in the past six months, please bring them with you to the exam.
☺ If you are currently wearing an **orthodontic appliance or TMJ Splint**, please bring it with you to the exam.
☺ Are there any other medical or dental conditions that we should know about? □ No, if □ Yes, Comment: ____
____

I, the undersigned, have completed this medical and dental health history and certify that the preceding information is true and correct. This practice cannot be held responsible for any problems arising out of inadequate information not disclosed here. If there are any future changes in this information, I will inform this practice of these changes. I also understand that credit bureau reports may be obtained when appropriate.

Signature of person filling out this history: ____ Date completed/signed: __________________

Signature of person who reviewed this history: ____Date completed/signed: __________________

Paul H. Rigali, D.D.S., P.C. *Diplomate of the American Board of Orthodontics*
217 103D Maxham Meadow Way • Suite 3D, Sunset Farm • Woodstock • Vermont •05091
Phone: 802-432-1087 • **Fax**: 802-432-1088
Email: orthodontix@rigaliorthodontix.com • **Website**: rigaliorthodontix.com