

**JEFFREY D. BERT, D.D.S., M.D.Sc., P.C.**  
**Practice Limited to Orthodontics**

**ADULT QUESTIONNAIRE**

Thank you for taking the time to provide us with the essential information. It will be used each time we select the safest and most effective means of providing you with dental care. All information on this form is completely confidential.

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Family Dentist \_\_\_\_\_ Family Physician \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person responsible for payment? \_\_\_\_\_

Employer / Division \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Business Address \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_  
S.S. # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Orthodontic Coverage Yes ( ) No ( )

Spouse's Name \_\_\_\_\_  
Employer / Division \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Business Address \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_  
S.S. # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Orthodontic Coverage Yes ( ) No ( )

**DENTAL HISTORY**

1. When was your last dental exam? \_\_\_\_\_
2. Have you ever had orthodontic treatment or been treated for a bad bite? ..... Yes ( ) No ( )
3. Have you ever had periodontal or gum disease? ..... Yes ( ) No ( )
4. Are you missing any teeth? ..... Yes ( ) No ( )
5. Do you wear a partial or a full denture? ..... Yes ( ) No ( )
6. Are you aware of any clicking, popping or grating noises in your jaw..... Yes ( ) No ( )
7. Do you clench or grind your teeth? ..... Yes ( ) No ( )
8. Have you noticed lumps, sores or irritated areas in your mouth? ..... Yes ( ) No ( )
9. Does food catch between your teeth? ..... Yes ( ) No ( )
10. Have you ever been treated for problems of your jaw joint or for facial muscle spasm..... Yes ( ) No ( )
11. Do you have either of the following habits: history of thumb sucking..... Yes ( ) No ( )  
mouth breathing..... Yes ( ) No ( )

What do you wish to gain through orthodontic treatment? \_\_\_\_\_

Additional information we should know? \_\_\_\_\_

MEDICAL HEALTH HISTORY

1. Please describe your present health..... Excellent ( ) Good ( ) Fair ( ) Poor ( )
2. Has your health CHANGED in the last year?.....Yes ( ) No ( )
3. Have you ever been HOSPITALIZED for illness or surgery.....Yes ( ) No ( )
4. Has a doctor treated you for any condition in the last two years? .....Yes ( ) No ( )  
Please describe: \_\_\_\_\_
5. Are you ALLERGIC to any drugs or other substances? .....Yes ( ) No ( )  
Please list: \_\_\_\_\_
6. Have you ever experienced BLEEDING that was difficult to stop? .....Yes ( ) No ( )
7. Has anyone in your family ever had DIABETES?.....Yes ( ) No ( )
8. Are you required to restrict your work or ACTIVITY? .....Yes ( ) No ( )
9. Is your DIET restricted or specially prescribed? .....Yes ( ) No ( )
10. Are you taking any MEDICATIONS (aspirin, vitamins, hormones, etc)? .....Yes ( ) No ( )  
If so please list them with dosages: \_\_\_\_\_

PLEASE INDICATE YES OR NO FOR ANY CONDITION, EVEN IF YOU NO LONGER HAVE IT.

- |                        |                |                                      |                |                         |                |
|------------------------|----------------|--------------------------------------|----------------|-------------------------|----------------|
| Heart Trouble          | Yes ( ) No ( ) | Hepatitis.....                       | Yes ( ) No ( ) | Emotional Problems      | Yes ( ) No ( ) |
| Heart Murmur           | Yes ( ) No ( ) | Jaundice.....                        | Yes ( ) No ( ) | or Tension.....         | Yes ( ) No ( ) |
| Heart Surgery.....     | Yes ( ) No ( ) | Diabetes.....                        | Yes ( ) No ( ) | Often Thirsty.....      | Yes ( ) No ( ) |
| Rheumatic Fever.....   | Yes ( ) No ( ) | Kidney Disease.....                  | Yes ( ) No ( ) | Often Fatigued.....     | Yes ( ) No ( ) |
| Congenital Heart       |                | Liver Disease.....                   | Yes ( ) No ( ) | Frequent Urination....  | Yes ( ) No ( ) |
| Lesions/Defects.....   | Yes ( ) No ( ) | Asthma.....                          | Yes ( ) No ( ) | Frequent Headaches...   | Yes ( ) No ( ) |
| Heart Pacemaker.....   | Yes ( ) No ( ) | Lung Disease.....                    | Yes ( ) No ( ) | Heavy Smoker.....       | Yes ( ) No ( ) |
| Heart Valve            |                | Tuberculosis.....                    | Yes ( ) No ( ) | Nervous/Anxious.....    | Yes ( ) No ( ) |
| Prosthesis.....        | Yes ( ) No ( ) | Bronchitis.....                      | Yes ( ) No ( ) | Depressed/Unhappy...    | Yes ( ) No ( ) |
| Heart Attack.....      | Yes ( ) No ( ) | Frequent Colds/<br>Sore Throats..... | Yes ( ) No ( ) | Recent Weight Loss...   | Yes ( ) No ( ) |
| High Blood Pressure... | Yes ( ) No ( ) | Ankles Swell.....                    | Yes ( ) No ( ) | Emphysema.....          | Yes ( ) No ( ) |
| Low Blood Pressure...  | Yes ( ) No ( ) | Sinus Trouble.....                   | Yes ( ) No ( ) | Epilepsy.....           | Yes ( ) No ( ) |
| Hardening of the       |                | Fainting.....                        | Yes ( ) No ( ) | Swollen Glands.....     | Yes ( ) No ( ) |
| Arteries.....          | Yes ( ) No ( ) | Ulcers.....                          | Yes ( ) No ( ) | Nasal Obstructions..... | Yes ( ) No ( ) |
| Artificial Joints..... | Yes ( ) No ( ) | Stroke.....                          | Yes ( ) No ( ) | Immune System           |                |
| Shortness of Breath    |                | Scarlet Fever.....                   | Yes ( ) No ( ) | Problems.....           | Yes ( ) No ( ) |
| on mild exertion.....  | Yes ( ) No ( ) | Venereal Disease.....                | Yes ( ) No ( ) | Arthritis.....          | Yes ( ) No ( ) |
| Chest Pains            |                | Glaucoma.....                        | Yes ( ) No ( ) | Hives/Rash.....         | Yes ( ) No ( ) |
| on mild exertions..... | Yes ( ) No ( ) | Infections.....                      | Yes ( ) No ( ) | Thyroid/Parathyroid     |                |
| Psychiatric Care.....  | Yes ( ) No ( ) | Anemia/Blood                         |                | Disorders.....          | Yes ( ) No ( ) |
| Hay Fever.....         | Yes ( ) No ( ) | Disease.....                         | Yes ( ) No ( ) | Tumors/Growths.....     | Yes ( ) No ( ) |
| AIDS.....              | Yes ( ) No ( ) |                                      |                | Cancer Treatment.....   | Yes ( ) No ( ) |
|                        |                |                                      |                | Recurrent Illness.....  | Yes ( ) No ( ) |

IF FEMALE, ARE YOU:

- Taking Birth Control Pills? .....Yes ( ) No ( )  
 In or Past Menopause? .....Yes ( ) No ( )  
 Pregnant? .....Yes ( ) No ( )  
 Have you ever taken bisphosphonates?  
 (Actonel, Boniva, Didronel, Fosamax, Skelid, Aredia, Zometa)..... Yes ( ) No ( )

IS THERE ANY OTHER CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please advise Dr. Bert of health changes at your next appointment.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_

