**JEFFREY D. BERT, D.D.S., M.D.Sc., P.C.**
**Practice Limited to Orthodontics & Dentofacial Orthopedics**
**Child & Adolescent Questionaire**

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______ Phone #_________________Cell # ______________
Home Address_________________________ City________________________ State______ Zip_________________
S.S. # _______________ Family Dentist_______________________ Family Physician_________________________
Whom may we thank for referring you? ________________________________________________________________
Person responsible for payment _______________________________________________________________________

Father's Name______________________________________________ E-Mail Address___________________________
Home Address if different from above_________________________ Phone #_________________________________
Employer/Division__________________________________________ Cell # __________________________________
Business Address_______________________________________________________________________________
Occupation________________________________________________ Business Phone # _________________________
S.S. #___________________ Group #________________________ Birth Date ________________________________
Insurance Company_________________________________________ Orthodontic Coverage Yes ( ) No ( )

Mother's Name_______________________________________________ E-Mail Address___________________________
Home Address if different from above_________________________ Phone #_________________________________
Employer/Division__________________________________________ Cell # __________________________________
Business Address_______________________________________________________________________________
Occupation________________________________________________ Business Phone # _________________________
S.S.#___________________ Group#___________________________ Birth Date________________________________
Insurance Company_________________________________________ Orthodontic Coverage Yes ( ) No ( )

Other Responsible Party______________________________________ E-Mail Address___________________________
Home Address if different from above _________________________ Phone #________________________________
Employer/Division__________________________________________ Cell # __________________________________
Business Address _______________________________________________________________________________
Occupation ________________________________________________Business Phone # _________________________
S.S. # ___________________ Group #___________________________ Birth Date________________________________
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 ( )
12. What do you wish to gain through orthodontic treatment? ____________________________________________
    ____________________________________________________________________________________
13. Additional information we should know? _________________________________________________________
    ____________________________________________________________________________________
    ____________________________________________________________________________________

**Please complete second page (over)**

**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: ____________________

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**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/ | Recent Weight Loss… Yes ( ) No ( ) |
| High Blood Pressure…Yes ( ) No ( ) | Sore Throats……… Yes ( ) No ( ) | Emphysema…………. Yes ( ) No ( ) |
| Low Blood Pressure… Yes ( ) No ( ) | Ankles Swell……….. Yes ( ) No ( ) | Epilepsy…………….. Yes ( ) No ( ) |
| Hardening of the | Sinus Trouble………. Yes ( ) No ( ) | Swollen Glands………Yes ( ) No ( ) |
| Arteries…………….Yes ( ) No ( ) | Fainting…………….. Yes ( ) No ( ) | Nasal Obstructions….. |
| Artificial Joints………Yes ( ) No ( ) | Ulcers………………. Yes ( ) No ( ) | Immune System Yes ( ) No ( ) |
| Shortness of Breath | Stroke………………..Yes ( ) No ( ) | Problems………….. Yes ( ) No ( ) |
| on mild exertion……Yes ( ) No ( ) | Scarlet Fever…………Yes ( ) No ( ) | Arthritis………………Yes ( ) No ( ) |
| Chest Pains | Venereal Disease…….Yes ( ) No ( ) | Hives/Rash………….. |
| on mild exertions…..Yes ( ) No ( ) | Glaucoma……………Yes ( ) No ( ) | Thyroid/Parathyroid Yes ( ) No ( ) |
| Psychiatric Care…….. Yes ( ) No ( ) | Infections…………….Yes ( ) No ( ) | Disorders…………... Yes ( ) No ( ) |
| Hay Fever…………… Yes ( ) No ( ) | Anemia/Blood | Tumors/Growths……. Yes ( ) No ( ) |
| AIDS…………………Yes ( ) No ( ) | Disease……………Yes ( ) No ( ) | Cancer Treatment…… Yes ( ) No ( ) |
| | | Recurrent Illness……. Yes ( ) No ( ) |

IF FEMALE ARE YOU:
Taking Birth control pills……………………….Yes ( ) No ( ) Pregnant………………………Yes ( ) No ( )

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

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

PARENT or GUARDIAN: ____________________ RELATIONSHIP TO PATIENT____________________

SIGNATURE: ____________________ DATE: ____________________

REVIEWED BY: ____________________