JAMES M. FAULKNER, D.D.S.
COREY J. TEGUIS, D.M.D.
SPECIALIST IN ORTHODONTICS

ORTHODONTIC ACQUAINTANCE QUESTIONNAIRE

Please fill out and bring with you to your first appointment! SEX M F Age________________

Patient's Name_______________________________________Nickname___________________Birthdate____________________

Hobbies and interests____

Address____City/Town______________________________Zip_________________

Phone numbers (Home)____(Work)__________________________________

E-mail address____

Referred by____

Dentist____Physician____

What is the patient's main concern?____

Who is responsible for payment? ____

Do you have insurance? ________________________Orthodontic coverage? ________________________

Do you have Maine Care?______________________ NH Healthy Kids?____________________________

Guardian's Name______________________________________Relationship________________ Home Phone________________

Home Address ____ Cell Phone _________________

Employer____Work Phone ________________

Guardian's Name______________________________________Relationship________________ Home Phone________________

Home Address ____ Cell Phone _________________

Employer____Work Phone ________________

Names and ages of siblings?____

Have any had orthodontic treatment? _________________

Are there any speech problems? _____________________

Is the patient a mouth breather?______________________Are their tonsils and adenoids present? ______________________

Have you been informed of any missing or extra permanent teeth? ____

Are the third molars present? ________________________ Impacted? ________________________

Does the patient have any oral habits: Thumb sucking, or finger or object biting? ___________________________________

How long since last dental checkup? __________________Is all dental work completed? __________________________________

Has the patient had any dental or medical x-rays within the past 6 months? ____

Have there been any injuries to the head, neck, mouth, or teeth? ____

Does the patient?

Grind or clench teeth? ___________Have jaw noises? ___________Have jaws lock? ___________Have bleeding gums? _________

Have head or backaches? ___________ Have frequent decay? ___________Take fluoride tablets daily? ___________

Use fluoride mouth rinse? ___________Is the patient on any medications? ___________If so what? ___________

MEDICAL HISTORY

Now/past/never	Now/past/never	Now/past/never	Now/past/never
__/__/__Arthritis	__/__/__Hypoglycemia	__/__/__Heart condition	__/__/__Kidney problems
__/__/__Allergies	__/__/__Epilepsy	__/__/__Rheumatic Fever	__/__/__Chest pain
__/__/__Asthma	__/__/__Fainting spells	__/__/__Scarlet Fever	__/__/__Diabetes
__/__/__Lung problems	__/__/__Parkinson's	__/__/__Ear Problems	__/__/__Swallowing difficulties
__/__/__Tuberculosis	__/__/__Learning Disability	__/__/__Cancer	__/__/__Stroke
__/__/__Skin problem	__/__/__Cerebral Palsy	__/__/__Radiation Treatment	__/__/__Mononucleosis
__/__/__Canker sore	__/__/__Multiple Sclerosis	__/__/__Bruise or bleed easily	__/__/__Hearing problems
__/__/__Cold sores	__/__/__Hyperactivity	__/__/__Birth Trauma	__/__/__High blood pressure
__/__/__Hepatitis	__/__/__Downs Syndrome	__/__/__Pregnancy	__/__/__Venereal Disease

Signature____Date__________________

DR. JAMES M. FAULKNER **DR. COREY J. TEGUIS**

James M. Faulkner, D.D.S.

Corey J. Teguis D.M.D.

Insurance Questionnaire

There have been new changes with the privacy laws that require us to obtain proper information from you regarding your insurance.

Please complete all information below and sign at the bottom. Giving us the correct information will allow us to serve you better.

Name and Address of Dental Insurance

____

____

____

Insurance Company's Phone #____

Name of Policy Holder____

Policy Holder's Date of Birth____

Policy Holder's Employer____

Social Security # / Policy ID #____

Group #____

Thank you for your cooperation.

____

Signature of patient/parent