Quentel & Henson Orthodontics

Manfred Quentel, D.D.S. -- James S. Henson, D.D.S.

ORTHODONTICS

7810 FM 1960 E., Suite #105

Humble, TX 77346

Date _____

1 PATIENT INFORMATION

Name: _____ _____ Phone (____) _____
First Mi Last Called Name

Address: _____ Birthday _____

City: _____ State: _____ Zip: _____ Age: _____ Sex: _____

2 ADULT INFORMATION

EMAIL: _____

FATHER or SELF or GUARDIAN INFORMATION

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

Driver's License #: _____ S.S. #: _____

How Long at This Address _____ How Long at Previous Address _____

Previous Address if Less Than 3 Years: _____

EMPLOYER/INSURANCE INFORMATION

Employer Name: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Number of Years Employed _____ Occupation _____

Orthodontic Coverage ? Yes___ No___

Insurance Company Name: _____

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone: _____ ext: _____

Group #: _____ Local or Union #: _____

MOTHER or SPOUSE INFORMATION

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

Driver's License #: _____ S.S. #: _____

How Long at This Address _____ How Long at Previous Address _____

Previous Address if Less Than 3 Years: _____

EMPLOYER/INSURANCE INFORMATION

Employer Name: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Number of Year Employed _____ Occupation _____

Orthodontic Coverage ? Yes___ No___

Insurance Company Name: _____

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone: _____ ext: _____

Group #: _____ Local or Union #: _____

3 OTHER INFORMATION

Who is the Responsible Party: _____

Who may we thank for referring you? _____

Dentist Name: _____

Sports or Hobbies: _____

Address: _____ Phone #: _____

School Name: _____ Grade: _____

Physician Name: _____

Number of Brothers: _____ Ages: _____

Address: _____ Phone #: _____

Number of Sisters: _____ Ages: _____

4 MEDICAL INFORMATION

	YES	NO
Frequent or Severe Headaches:		
Any Heart Disease:		
Any Sinus or Respiratory Disease:		
Any Blood Disease:		
Any Liver Disease:		
Any Thyroid Disease:		
Any Kidney Disease:		
H.I.V. Positive:		
Any Venereal Disease:		
Any Intestinal Disease:		
Any Bone Disease:		
Any Nervous /Emotional Problems:		
Any High or Low Blood Pressure:		
Any Endocrine Problems:		
Any Problems with Wounds Healing:		
Any Tumors or Cancer:		
Tonsilitis/Frequent Sore Throats:		
Any Joint Problems:		

	YES	NO
Rheumatic/Yellow/Scarlet Fever:		
Acquired Immune Deficiency Syndrome:		
Is Patient Under Medical Care:		
Rheumatism or Arthritis:		
Is the Patient taking any Medications:		
A History of Fainting or Dizziness:		
Does the Patient have a Drug Addiction:		
Is the Patient Pregnant at this Time:		
Measles/Mumps/Chicken Pox:		
Does the Patient Smoke:		
Has the Patient ever had Fever Blisters:		
Is Height & Weight Normal for Age:		
Is the Patient in Good Health:		
Has the Patient had a Physical this Year:		
Has the Patient Reached Puberty:		
If Male, Begun to Shave:		
If Female, Begun to Menstruate:		

	YES	NO
Heart Murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		

	YES	NO
Asthma or Hay Fever:		
Tuberculosis:		
Any Broken Bones:		
Prolonged Bleeding:		
Yellow Jaundice:		
Radiation Therapy:		
Chemical Therapy:		
Blood Transfusions:		
Latex Allergy:		

Is the Patient Allergic to Anything: ____
What: ____

Are you aware of any other disease, condition, or problem not listed above that we should know about:
If Yes, What: ____

Any Unusual Reactions to Any of the Following:
Asprin: ____ Sulfa Drugs: ____
Barbiturates: ____ Other Medications: ____
Penicillin: ____

List Any Medications Currently Taking: ____

Please Explain: ____

5 DENTAL HISTORY

	Yes	No
Has the Patient Seen a General Dentist in the Last Year:		
Any Pain, Clicking or Discomfort In or Near the Ears:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Have You Been Informed of Missing or Extra Permanent Teeth:		
Are You Aware of Any **"Gum"** Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		
Do You Feel the Patient can Benefit From Orthodontic Treatment:		
Is the Patient Happy with Their **"SMILE"**:		
Does the Patient Want to Improve Their **"SMILE"** and **"BITE"**:		
Would the Patient Mind Wearing **"BRACES"**:		

When are Patient's Teeth Brushed:

After Breakfast:		
After Lunch:		
After Dinner:		
Before Bed:		

Does the Patient Have or Ever Had Any of the Following Habits:

	Yes	No
Cheek, Tongue or Lip Chewing:		
Thumb Sucking:		
Mouth Breathing:		
Finger Nail Biting:		

	Yes	No
Clenching Teeth:		
Tongue Thrusting:		
Grind Teeth:		
Speech Problems:		

	Yes	No
Has the Patient Been Examined by an Orthodontist Before:		
If Yes, When: ____		
Have Other Members of the Family had Orthodontic Treatment:		
If Yes , Were You Happy With the Results:		

If No, Why: ____

Patients Attitude Toward Braces:
Eagerness: ____
Complacency: ____
Willingness: ____
Antagonism: ____

Who First Noticed the Orthodontic Problem:
Parent: ____
Patient: ____
Dentist: ____
Other: ____

In Your Own Words What is the Orthodontic Problem: ____

What Would you Like Orthodontic Treatment to Accomplish: ____

Patient Signature **Date** **Parent Signature**

6 FOR OFFICE USE ONLY
