Family Orthodontics

Eric B. Lowenhaupt, D.D.S. &
Christopher J. West, D.M.D., M.S., M.B.A., M.S.

1851 W. Indiantown Rd., Suite 201
Jupiter, FL 33458
561-744-5456, Fax 561-744-9803
christopherwestdmd@hotmail.com

Welcome to our office. So that we can best meet your orthodontic needs, please complete both sides of this medical/dental questionnaire. When you have finished please return it to one of our staff members and we will be with you shortly. Thank you.

PATIENT'S NAME:_____BIRTHDATE:_____

AGE:_____ SEX: M F (H)PHONE:_____(C)PHONE:_____

HOME ADDRESS:_____

SPOUSE'S NAME:_____

PATIENT'S EMPLOYER:_____(W)PHONE:_____

PATIENT'S DENTIST:_____PHYSICIAN:_____

HOW DID YOU HEAR ABOUT US?_____

Please complete this section if the patient is a minor. Thank you.

SCHOOL:_____GRADE:_____

FATHER'S NAME:_____SSN:_____

HOME ADDRESS (if different):_____(H)PHONE:_____

EMPLOYER:_____(W)PHONE:_____(C)PHONE:_____

MOTHER'S NAME:_____SSN:_____

HOME ADDRESS (if different):_____(H)PHONE:_____

EMPLOYER:_____(W)PHONE:_____(C)PHONE:_____

PERSON RESPONSIBLE FOR THE ACCOUNT:_____

Please provide us with your financial and insurance information.

ARE YOU INTERESTED IN FINANCING YOUR ORTHODONTIC TREATMENT? Y N

DO YOU HAVE INSURANCE WHICH INCLUDES ORTHODONTICS? DON'T KNOW Y N

NAME OF INSURED:_____ID# / SSN:_____

INSURANCE COMPANY: _____PHONE:_____

PLEASE COMPLETE OTHER SIDE

POLICY NUMBER:_____INSURED DOB:_____

Patient Medical History

Y N ARE YOU IN GOOD HEALTH?
Y N ARE YOU UNDER THE CARE OF A PHYSICIAN?
IF SO, FOR WHAT REASON?_____
_____
Y N ARE YOU TAKING ANY MEDICATIONS?
IF SO, PLEASE LIST._____
_____
Y N DO YOU HAVE ANY ALLERGIES?
IF SO, PLEASE LIST._____
_____

DOES THE PATIENT HAVE A HISTORY OF:

Y	N	ASTHMA?	Y	N	SLEEP APNEA?
Y	N	BREATHING PROBLEMS?	Y	N	MOUTH BREATHING?
Y	N	SWALLOWING PROBLEMS?	Y	N	EAR PROBLEMS?
Y	N	TONSILS OR ADENOIDS REMOVED?	Y	N	SPEECH PROBLEMS?
Y	N	HEART PROBLEMS?	Y	N	RHEUMATIC FEVER?
Y	N	SEIZURES/EPILEPSY?	Y	N	DIABETES?
Y	N	PROLONGED BLEEDING?	Y	N	HIV OR HEPATITIS?

Patient Dental History

Y N HAVE YOU HAD A RECENT DENTAL CHECK-UP? IF SO, WHEN?_____
Y N HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT OR AN ORTHODONTIC CONSULTATION?
IF SO, WHEN AND WHERE?_____
Y N DOES ANYONE ELSE IN THE FAMILY HAVE A SIMILAR BITE?
IF SO, WHO?_____
Y N IS THE PATIENT ADOPTED?

DOES THE PATIENT HAVE A HISTORY OF:

Y N TRAUMA TO THE FACE OR TEETH?
Y N THUMB OR FINGER SUCKING HABIT?
Y N NIGHT TIME TEETH GRINDING HABIT?
Y N LOSS OF PERMANENT TEETH?
Y N CLEFT LIP OR PALATE?
Y N PAIN OR TENDERNESS IN THE JAW JOINTS?
Y N SOUNDS OR CLICKING IN THE JAW JOINTS WHEN OPENING OR CLOSING?
Y N DIFFICULTY CHEWING OR EATING?
Y N SORES OR ULCERS IN THE MOUTH?
Y N COLD SORES OR FEVER BLISTERS?
Y N ENDODONTIC TREATMENT/ROOT CANAL THERAPY
Y N DENTAL CROWNS OR BRIDGES?
Y N DENTAL IMPLANTS?

SIGNATURE:_____DATE:_____