

ACQUAINTANCE AND HISTORY QUESTIONNAIRE

John R. Frick, D.D.S., P.A.
Practice Limited to Orthodontics

Please Print

Name _____ Birthdate _____

Name you preferred to be called _____ Sex M F e-mail _____

Address _____ Phone _____

_____ Zip Code _____

Occupation _____ Bus. Phone _____

Marital Status: Married ___ Single ___ Other ___

Spouse's name _____ Occupation _____

Your dentist _____ Your Physician _____

Whom may I thank for recommending our office to you? _____

What problem(s) about your teeth led you to seek our advice? _____

Please check the following as they apply to your medical history:

YES	NO		YES	NO	
___	___	hepatitis	___	___	bleeding problems
___	___	tuberculosis	___	___	diabetes
___	___	fainting or dizzy spells	___	___	frequent headaches
___	___	allergies or asthma	___	___	tonsils removed
___	___	night grinding of teeth	___	___	epilepsy
___	___	frequently stuffed nose	___	___	rheumatic fever
___	___	learning disability:ADD, ADHD	___	___	heart disease
___	___	psychiatric treatment	___	___	speech problems
___	___	nervous emotional disturbance	___	___	HIV pos./AIDS
___	___	premedication for dental procedures	___	___	hearing problems
___	___	injury to mouth			
___	___	pain related to teeth or jaw			

Additional information or comments on the above responses: _____

Are you presently in excellent health? YES___ NO___

Are you now taking any medication or being treated by a physician? YES___ NO___

If yes, please explain and list medications:_____

Have any members of your family had more or less than
The normal number of teeth to form? YES___ NO___

Have any other family members had orthodontic treatment?
If yes, were they treated by Dr. Frick YES___ NO___

Name and relationship of family member treated by Dr. Frick:_____

If treatment is performed here, please list the person accepting financial responsibility:

Name_____ email_____

Address_____ Phone_____

City_____ Zip code_____

To the best of my knowledge all the above information is true and correct, and I assume the responsibility to inform Dr. Frick's office of any health-related changes. I authorize Dr. Frick and practice to release health care information to other physicians or dentists regarding treatment and care. Once released information leaves the office, I know Dr. Frick has no control over the information being re-disclosed by the receiving physician.

Signature

Today's Date

Please present this questionnaire at the examination appointment.