320 Thomas More Parkway
Crestview Hills, KY 41017
859-341-9400
FAX 859-578-4561

Quast ORTHODONTICS

DAVID C. QUAST, D.M.D., M.S.D.
Specialist in Orthodontics and Dentofacial Orthopedics

Patient motivation for treatment

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us understand your problem by checking the following information; please be specific (circle the words *more, less, forward, backward, longer, shorter*, etc.):

1. The teeth

If your teeth could be changed, how would you like them to change?

( ) straighten the front teeth upper / lower
( ) straighten the back teeth upper / lower
( ) make the upper front teeth longer / shorter
( ) move upper teeth forward / backward
( ) move lower teeth forward / backward
( ) make the line of the upper front teeth more level
( ) other:

2. the face

If your facial appearance could be changed, what would you change?

( ) get rid of sag under lower jaw
( ) move chin forward / backward
( ) move chine left / right to center it
( ) move lower lip forward / backward
( ) move upper lip forward / backward
( ) move the area around my nose forward / backward
( ) make the profile of my nose longer / shorter
( ) move the area under my eyes forward / backward
( ) make my cheekbones larger / smaller
( ) show more / less of my teeth / gums when I smile
( ) make my lips closer together / farther apart when my teeth are touching
( ) make my lips not touch and roll out when my teeth are touching
( ) reduce the strain in my chin / lips when I close my lips
( ) make my face more narrow / wide
( ) reduce the width / fullness of my lower jaw behind my mouth
( ) other:

3. symptoms

If you want to reduce pain or discomfort where would it be located? Please be specific about the location; circle the right side, left side or both if they apply.

( ) in front of my ears right / left
( ) below my ears right / left
( ) above my ears right / left
( ) in my ears right / left
( ) neck right / left
( ) shoulders right / left
( ) temples right / left
( ) teeth
( ) sinuses
( ) eyes right / left
( ) other:

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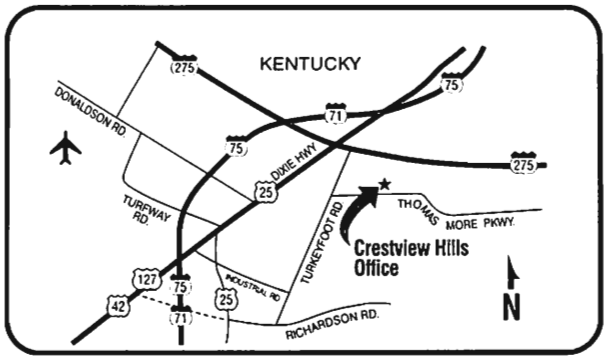

Dear: _____

We are pleased that you called our office for your orthodontic treatment. At this appointment a preliminary orthodontic evaluation will be made and a preliminary diagnosis will be given. This appointment will take about one hour. Should orthodontic treatment be recommended, diagnostic records will be prescribed. In order to save yourself a second visit for diagnostic records, please allow for a two hour visit.

We are looking forward to meeting with you: M T W Th F S_____ at _____ am / pm

Please fill in the following questionnaire and bring it to your appointment. Thank you!

Patients Name: _____ Birthdate:_____ Age: _____
(Last / First / Middle)

Address: _____
(Number / Street / City / State / Zip)

Home Phone Number: _____ Work Number: _____ Social Security # _____
(If Applicable)

RESPONSIBLE PARTY INFORMATION

Name:_____ Birthdate:_____
(Last / First / Middle)

Relationship To Patient: _____ Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed ☐ remarried

Address (if different than patient): _____
(Number / Street / City / State / Zip)

How Long At Above Address:_____ Home Phone Number: _____ Social Security #: _____

Previous Address If Less Than 3 Years: _____
(Number / Street / City / State / Zip)

Employer:_____ Occupation: _____

Years Employed:_____ Work Phone Number: _____ Cell: _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name:_____ Relationship To Patient: _____
(Last / First / Middle)

Primary Insurance Company: _____ Subscribers #: _____

Insurance Company Address: _____
(Number / Street / City / State / Zip)

Insurance Company Phone #: _____ Insured's Employer:_____

Do You Have Dual Coverage? (If so, please fill out the following information)

Insured's Name:_____ Birthdate: _____
(Last / First / Middle)

Secondary Insurance Company: _____ Subscribers #:_____

Insurance Company Address:_____
(Number / Street / City / State / Zip)

Insurance Company Phone #: _____ Insured's Employer:_____

I understand that when appropriate, credit bureau reports may be obtained:

Signature: _____ Responsible Party

Medical History for (Name):_____

What is the name of your family physician? _____ Date of your last visit to this physician: _____

Are there any Medical Specialists that you see regularly? _____ Specialty: _____

When was the last time you had a complete physical exam? Date _____ Examining doctor's name: _____

What is your approximate height?__ feet,__ inches. What is your approximate weight?_____pounds

Body Frame size: ☐ Small ☐ Medium ☐ Large

History of:			Specifics of Problems if *YES:*	*Please Explain...Also indicate any Medication (& dosage)*
Head/Neck Problems?	NO ☐	**YES** ☐	Headaches: Migraine ☐ Sinus ☐ Eyes ☐ Temples ☐ Back of head ☐ Painful Scalp ☐ Neck Pain ☐ Lumps in Neck ☐ Tired/Sore Neck Muscles ☐	
Neural Problems?	NO ☐	**YES** ☐	Epilepsy ☐ Seizures ☐ Numbness/Tingling ☐ Other ☐	
Eye Problems?	NO ☐	**YES** ☐	Pain ☐ Bloodshot ☐ Blurred Vision ☐ Pressure on Eyeballs ☐ Light Sensitivity ☐ Watery ☐ Drooping Eyelids ☐ _____	
Ear Problems?	NO ☐	**YES** ☐	Pain ☐ Clogged ☐ Hissing ☐ Ringing ☐ Dizziness ☐ Nausea ☐ Loss of Hearing Volume ☐ Loss of Balance ☐	
Nose/Sinus Problems?	NO ☐	**YES** ☐	Obstruction ☐ Stuffiness ☐ Runny Nose ☐ _____	
Throat Problems?	NO ☐	**YES** ☐	Sore Throat ☐ Swallowing Difficulties ☐ Lump in Throat ☐ Laryngitis ☐ Voice Fluctuations ☐ Tongue Pain ☐ Persistent Coughing/Clearing Throat ☐	
Breathing Problems?	NO ☐	**YES** ☐	Asthma ☐ Wheezing ☐ Shortness of Breath ☐ Chronic Cough ☐ Cough up Blood/Sputum ☐ Snoring ☐ Sleep Apnea ☐	
Back, Shoulders, Extremity Problems?	NO ☐	**YES** ☐	Aching Shoulders ☐ or Stiffness ☐ Lack of Mobility ☐ Upper ☐ Lower ☐ Back Pain ☐ Numbness in Arms ☐ Cramps in Legs When Walking ☐ At Night ☐ Arms/Legs Weakness ☐ Leg/Ankle Swelling ☐ Gout ☐	
Bone Problems?	NO ☐	**YES** ☐	Break easily ☐ Pain ☐ Arthritis ☐ Joint Pain ☐ Joint Swelling ☐	
Breast Problems?	NO ☐	**YES** ☐	Pain ☐ Lumps ☐ Disease ☐ _____ _____	
Heart Problems?	NO ☐	**YES** ☐	Coronary Heart Disease ☐ Heart Valve Disease ☐ High Blood Pressure ☐ Chest Pain ☐ Angina ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Palpitations ☐ Rheumatic Heart Disease ☐ Congenital Heart Disease ☐ Mitral Valve Prolapse ☐	
Urinary System Problems?	NO ☐	**YES** ☐	Urgency ☐ Painful Urination ☐ Frequent Urination ☐ Nighttime Urination ☐ Release when Sneeze/Cough ☐ Blood in Urine ☐ Kidney Infection ☐	
Stomach & Intestine Problems?	NO ☐	**YES** ☐	Ulcers ☐ Bleeding ☐ Abdominal Pain ☐ Heartburn ☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Gall Bladder Disease ☐ Intestinal Disease ☐ Black Stool ☐ Intolerance to: Milk ☐ Eggs ☐	
Endocrine Problems?	NO ☐	**YES** ☐	Pancreas ☐ Thyroid ☐ Pituitary ☐ _____	

DR's. Initials _____

TC's Initials _____

History of:		Specifics of Problems if *YES:*	*Please Explain...Also indicate any Medication (& dosage)*
Liver Problems?	NO ☐ **YES** ☐	_____	_____
Kidney Problems?	NO ☐ **YES** ☐	_____	_____
Blood Problems?	NO ☐ **YES** ☐	Hemophilia ☐ Anemia ☐ Bruise Easily ☐ Bleed Easily ☐ Blood Clots ☐ Had Stroke ☐	_____ _____
Chronic Disease Problems?	NO ☐ **YES** ☐	Diabetes ☐ Cancer ☐ Hepatitis A ☐ B ☐ C ☐ HIV+ ☐ Tuberculosis ☐ Infectious Diseases ☐ AIDS ☐ Swelling ☐ Tonsillitis ☐ Excessive Colds ☐	_____ _____ _____
Skin Problems?	NO ☐ **YES** ☐	Ezcema ☐ Dry ☐ Oily ☐ Itchy ☐	_____
One Time Problems?	NO ☐ **YES** ☐	Mumps (@ age____) Rheumatic Fever (@ age___) Measles (@ age____) Chicken Pox (@ age_____)	_____ _____
Heart Surgery?	NO ☐ **YES** ☐	Heart Valve (date_____) Pacemaker (date_____) Bypass (date_____) _____ (date_____)	_____ _____
Other Surgery?	NO ☐ **YES** ☐	Tonsils (date_____) Adenoids (date_____)	_____
Serious Injury?	NO ☐ **YES** ☐	Broken Bones (date_____) _____	_____
Occupational Disease?	NO ☐ **YES** ☐ (ADULTS)	_____ _____	_____ _____

Family History of:			If Yes, Which Family Members:	Comments on Family History of Diseases:
Diabetes?	NO ☐	**YES** ☐	_____	_____
Cancer or Skin Cancer?	NO ☐	**YES** ☐	_____	_____
Infectious Disease?	NO ☐	**YES** ☐	☐ Tuberculosis ☐ Hepatitis ☐ HIV+ ☐ AIDS	_____
Heart Disease?	NO ☐	**YES** ☐	_____	_____
High Blood Pressure?	NO ☐	**YES** ☐	_____	_____
Organ Disease?	NO ☐	**YES** ☐	☐ Liver ☐ Kidney ☐ Lung	_____
Kidney Disease?	NO ☐	**YES** ☐	_____	_____
Lung Disease?	NO ☐	**YES** ☐	_____	_____
Emotional Problems?	NO ☐	**YES** ☐	_____	_____
Stroke?	NO ☐	**YES** ☐	_____	_____
Arthritis?	NO ☐	**YES** ☐	_____	_____

Habit Excesses?	NO ☐	**YES** ☐	Smoking (___Packs/Day) for_____years Caffeine ☐ Alcohol ☐ Over Eating ☐	_____ _____
Exercise Regularly?	NO ☐	**YES** ☐	____ Hours/Day ☐ Week ☐ Month ☐	_____
Psychological Problems?	NO ☐	**YES** ☐	Anxiety ☐ Depression ☐ Psychiatric Disorder ☐	_____
Presently Taking Medications?	NO ☐ (Dosage?)	**YES** ☐	Insomnia ☐ _____ Birth Control ☐ Diuretics ☐ Blood Pressure ☐ Blood Thinners ☐ Heart ☐ Tranquilizers ☐ Anticonvulsant ☐ Insulin or similar drug ☐	_____ _____ _____
Allergic Reactions?	NO ☐	**YES** ☐	Hay Fever ☐ To Foods ☐ To Metals/Plastics ☐	_____
Drug Reactions?	NO ☐	**YES** ☐	Anti-Bacterial Drugs ☐ _____	_____
Anesthetic Reaction?	NO ☐	**YES** ☐	Local Anesthetic ☐ General Anesthetic ☐	_____

Child: **Has the Patient Reached Puberty?** Female started menstruation? NO ☐ **YES** ☐ Males had voice change? NO ☐ **YES** ☐ AT WHAT AGE? ____

Has a physician indicated that the patient is **MATURING:**
EARLIER than normal? NO ☐ **YES** ☐ NORMALLY? NO ☐ **YES** ☐
LATER than normal? NO ☐ **YES** ☐ _____

Women:
Are you pregnant now or do you think you may be? NO ☐ **YES** ☐
Do you anticipate becoming pregnant? NO ☐ **YES** ☐

DR's. Initials _____
TC's Initials _____

DENTAL HISTORY:

Name Of Your Family Dentist: _____ Date of your last visit to this dentist: _____

Dental Specialists who have Treated you (Give Names, Treatments & Dates): _____

How many times per day do you ***BRUSH*** your teeth? 0 ☐ 1 ☐ 2 ☐ 3+ ☐ How many times per day do you ***FLOSS*** your teeth? ☐ 0 ☐ 1 ☐ 2+

History Of:		Specifics of Problems if *YES*:	Please Explain any *YES* answers
Tooth Injury?	NO ☐ YES ☐	Chipped ☐ Broken ☐ Knocked Out ☐	
Oral Disease?	NO ☐ YES ☐	Ulcers ☐ Sores ☐	
Jaw Joint Pain?	NO ☐ YES ☐	**Right** T.M.J.: Constant ☐ Periodic ☐	When You: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐
		Left T.M.J.: Constant ☐ Periodic ☐	When You: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐
		Comments:	
Jaw Joint Noises?	NO ☐ YES ☐	**Right** T.M.J.: Click ☐ Popping ☐ Grating ☐ At age:	
		Left T.M.J.: Click ☐ Popping ☐ Grating ☐	
Jaw Joint Locking?	NO ☐ YES ☐	**Right** T.M.J.: When Open ☐ When Closed ☐ Dates of Locking	
		Left T.M.J.: When Open ☐ When Closed ☐	
Grinding Your Teeth?	NO ☐ YES ☐	During The Day ☐	
		When Sleeping ☐	
Clenching Your Teeth?	NO ☐ YES ☐	During The Day ☐	
		When Sleeping ☐	
Bleeding Gums?	NO ☐ YES ☐	Usually ☐ Sometimes ☐ Rarely ☐	Presently under a Dentist's care for it? Yes No
		When: Brushing ☐ Flossing ☐ Eating ☐	
Oral Habits?	NO ☐ YES ☐	Thumb Sucking ☐ Finger Sucking ☐	
		Tongue Thrusting ☐ Nail Biting ☐	
Other Oral Problems?		Speech Problems? NO ☐ YES ☐	Comments:
		Mouth Breathing NO ☐ YES ☐	Comments:
		Cleft Lip/Palate: NO ☐ YES ☐	

Have You Ever Had:

Teeth Extacted?	NO ☐ YES ☐	Which Teeth?
Periodontal (gums) Treatment?	NO ☐ YES ☐	What Kind Of Treatment?
Orthodontic (braces) Treatment?	NO ☐ YES ☐	What Kind Of Treatment?
Endodontic (root canal) Treatment?	NO ☐ YES ☐	What Kind Of Treatment?
Oral Surgery (jaw surgery) Treatment?	NO ☐ YES ☐	What Kind Of Treatment?
Prosthodontic (crown & bridge) Treatment?	NO ☐ YES ☐	What Kind Of Treatment?

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time. I will keep the doctor and staff of this practice informed of any changes in this information as it occurs.

_____ _____

Signature of Person Filling Out This Health History | **Date this history was completed**

_____ _____

Signature that the examination ***DOCTOR*** reviewed history | Date of Interview and ***DOCTOR*** review of this history

_____ _____

Signature of the T.C. who reviewed this health history | **Date above T.C. reviewed this health history**

Treatment modification advised: NO ☐ **YES** ☐ Comments: _____

Current medical problems: _____

Current medication: _____

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, *home addresses*, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____

Patient's Signature

_____

Print Name

_____

Date