Date: ________________

Welcome to Morrone, Kaye and Yucha Orthodontics

Initial Adult New Patient Questionnaire

The purpose of obtaining this information is to develop a comprehensive baseline plan just for you! In an effort to provide the best service possible, we ask you to fill this form out in order to help the doctor evaluate and treat you in the best clinical manner.

Phone Number:________________________ E-Mail:_______________________________

Patient Name: __________________________ DOB: ______________ Age: ____

Dentist: _________________________________

1. **How did you hear about us?**
   ____ Your Dentist
   ____ **Current MKY Patient; Name _____________________________**
   ____ Family Member
   ____ Online Research – Google Search, Website, Facebook, etc.
   ____ Neighborhood Reputation – Word on the Street, Soccer Field, etc.
   ____ Community event we sponsored

2. **What type of treatment options would you like discussed at today's visit?**
   ____ Traditional Metal Braces
   ____ Invisalign
   ____ Clear Braces
   ____ Retainers (to hold current position/limited tooth movement)
   ____ Other-please explain
   ____

3. **What is your main concern with your smile/bite?**
   ____

Children in current household, if any: Current Patient

Daughter/Son Name: _______________________ D.O.B. ________________ Y / N
Daughter/Son Name: _______________________ D.O.B. ________________ Y / N
Daughter/Son Name: _______________________ D.O.B. ________________ Y / N

MEDICAL HISTORY

Please check if you have or had any of the following:

( ) Allergy to Medication(s)

( ) Tonsils/Adenoids Removed

( ) Facial Injuries – Mouth, Chin

( ) HIV

( ) Asthma

( ) Emotional Issues/Anxiety

( ) Allergy to Plastic/Latex/Metal/Other

( ) Frequent Headaches

( ) Hepatitis A, B, or C

( ) Tongue Thrust, Thumb Sucking

( ) ADD/ADHD/Learning Disability

( ) Frequent Colds

Please explain any above checked answers: ____

____

Please state any other significant medical history: ___________________________________

____

Please list any medications currently being taken:__________________________________

____

Is antibiotic premedication needed for dental visits: Yes______ No______ Unsure ______

If Yes or Unsure, please explain: ____

Physician's Name: ____

The above information is true to my knowledge. I give my consent for examination of myself by the doctors and staff of Morrone, Kaye and Yucha Orthodontics, P.A.

_________________________ _________________________ ____________________

Signature Print Name Date