NEW PATIENT Orthodontic Questionnaire

Date _____
Patient Name _____
Patient DOB _____
Parent/Guardian Name _____
Email _____
Phone Home/Cell _____
Mailing Address _____
General Dentist's Name _____

We will be taking x-rays today. Is there any reason why we should NOT take an x-ray such as pregnancy?
☐ Yes ☐ No

Are you allergic to latex?
☐ Yes ☐ No

Do you have any problems with your jaw?
☐ Yes ☐ No

Are you in any dental pain?
☐ Yes ☐ No

At Boerne Orthodontics and Pediatric Dentistry, we want to offer a special plan just for you! Check all that apply.

1. *What treatment option are you most interested in?*
   - *Traditional Metal Braces*
   - *Clear Braces*
   - *Retainers Only*
   - *Invisalign*

2. *What payment options would be best for you?*
   - *Payment in Full with Special Discount*
   - *In Office Financing – No Interest*

3. *Is this your first orthodontic evaluation? ☐ Yes ☐ No*

4. *What motivated you to come in for an evaluation at this time?*

_____
_____
_____