

ADULT ORTHODONTIC ACQUAINTANCE FORM

Date _____

Patients name _____ Nickname _____

Home address _____ Telephone () _____

City _____ State _____ Zip _____ Date of birth ____/____/____ Age _____ Sex _____

Referred by _____ Patient's Dentist _____ Patient's Physician _____

Employer _____ Social Security # _____ Work telephone () _____

Dental insurance _____ Mobile telephone () _____

Spouses name _____ SS # _____ Birth Date ____/____/____

Address (if different) _____ Telephone () _____

Employer _____ Work telephone () _____

EMAIL ADDRESS FOR CONFIRMATIONS:

GENERAL APPRAISAL

Why did you make this appointment? _____

What is your concern about your teeth? _____

Do any family members have similar orthodontic problems? _____

Have any members of your family received orthodontic treatment? Y / N Who? _____ When? _____

Have you been evaluated or treated by another orthodontist? _____

Would you mind wearing braces? _____ Functional appliances _____ Retainers _____ Rubber bands _____

Any noticeable difficulty in chewing or swallowing food? Y / N _____

Have you ever been teased about the appearance of your teeth Y / N _____

Are you aware that some appointments will infringe on **school time** or **work time** Y / N _____

Hobbies, Activities, Special interest _____

Do you currently use tobacco products? _____ what type? _____

MEDICAL HISTORY

Are you in good health? Y / N explain _____

Do you have any history of major illness? Y / N explain _____

Check any of the following for which you have been treated:

- | | | | | |
|--|--|-----------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Fainting/dizziness |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Liver involvement |

Have tonsils/adenoids been removed? Y / N what age? _____

List any drugs or medications now being taken. Give reasons _____

List any allergies or drug sensitivities _____

Any allergies to **latex** or **metals**? ____ yes ____ no

DENTAL HISTORY

Have there been any injuries to face, mouth, or teeth? Y / N _____

Have you been informed of any missing or extra permanent teeth? _____

Do you have any speech problems? Y / N _____

Have you ever sucked a thumb or finger? Y / N until what age? _____

Are you a mouth breather? Y / N while awake? _____ While asleep? _____

How long since your last dentist visit? _____

Does your jaw pop, catch, click? _____

Signature of person responsible for account