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 ( ) _____

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 _____

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:

__ Diabetes	__Rheumatic Fever	__Epilepsy	__Kidney Involvement	__Fainting/dizziness
__ Pneumonia	__ Bone disorders	__Anemia	__ Endocrine problems	__ Nervous disorders
__ Heart trouble	__ Tuberculosis	__ Asthma	__ Prolonged bleeding	__ 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 _____

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