Adult Orthodontic Acquaintance Form

Date_____

Patient Name_____

Address_____

Home Phone #_____Cell #_____

Date of Birth_____ Email_____

Patient's Dentist_____

Physician_____

Whom can we thank for referring you to our office? _____

Employed by_____ Business Phone_____

Occupation_____ Soc. Sec. #_____

Business address_____

Name of spouse_____

Employed by_____ Business Phone_____

Occupation_____ Soc. Sec. # _____

Business address_____

Do you have orthodontic insurance? _____ Dental insurance? _____

Insurance company_____

Names and ages of children in family_____

MEDICAL HISTORY

Are you in good health? ○Yes ○No

Have you ever been hospitalized for a serious illness? ○Yes ○No

If yes, please explain: _____

Have you ever had any of the following?

Tire easily; Weakness	○Yes	○No	Persistent fever	○Yes	○No
Marked weight change	○Yes	○No	Blood transfusion	○Yes	○No
Night sweats	○Yes	○No			

Please circle any of the following for which you have been treated or diagnosed:

Diabetes	○Y ○N	Heart trouble	○Y ○N	Prolonged bleeding	○Y ○N
Pneumonia	○Y ○N	Rheumatic fever	○Y ○N	Fainting/dizziness	○Y ○N
Tuberculosis	○Y ○N	Bone disorders	○Y ○N	Nervous disorders	○Y ○N
Anemia	○Y ○N	Venereal disease	○Y ○N	Liver problems	○Y ○N
Epilepsy	○Y ○N	Kidney problems	○Y ○N	Psychological problems	○Y ○N
Asthma	○Y ○N	Endocrine problems	○Y ○N	Developmental disability	○Y ○N
HIV+	○Y ○N	Immunosuppression	○Y ○N		

Is there any disease, condition, or problem not listed above that you think we should know about?

If yes, please explain:_____

Do you have tendency to colds, sore throats, ear infections? ◯Yes ◯No

Have tonsils and adenoids been removed? ◯Yes ◯No

If yes, as a ◯child? or ◯adult?

List any drugs or medications now being taken, and give reasons:

_____

List any allergies or drug sensitivity_____

Women: Are you pregnant now, or think you may be? ◯Yes ◯No

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ◯Yes ◯No

If yes, please describe: _____

Have you ever had any of the following:

Do you clench your teeth? ◯Yes ◯No Do you grind your teeth? ◯Yes ◯No

Clicking/popping jaw? ◯Yes ◯No Difficulty opening/closing jaw? ◯Yes ◯No

Have you ever had a finger or thumb habit? ◯Yes ◯No Do you have speech problems? ◯Yes ◯No

Are you a mouth breather? ◯Yes ◯No While awake? ◯Yes ◯No While asleep? ◯Yes ◯No

Have you been informed of any missing or extra permanent teeth? ◯Yes ◯No

Have you consulted with an orthodontist previously? ◯Yes ◯No

Have you ever had orthodontic treatment? ◯Yes ◯No

If yes, please describe:_____

List any musical instruments played_____

Reason for consultation_____

Patient Signature_____

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